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## Difficult Patients

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### INTRODUCTION

Whenever and wherever health professionals congregate, it doesn't take long for the topic of difficult patients to surface. Patients and families we experience as difficult increase the personal frustration of delivering care, decrease our satisfaction with work, and make it almost impossible to deliver the person-centered care that is at the heart of high-quality, satisfying, effective health care. Why, we ask, would someone choose to come to the office or hospital and harass, abuse, ignore, or lie to us?

Fortunately, most difficult interactions are both diagnosable and repairable. Aside from the unusual individual who is determined to be difficult, many problematic situations are created by unsatisfactory communication between provider and patient or by personal issues the provider unknowingly brings into these important interactions. These issues can include reminders of similar problems within the provider's own world or negative reactions to the patient's physical condition, sexual orientation, or personality.

Medical educators are increasingly finding that practitioners consider patients difficult based on their similarity to others, often family members, with whom they have had interpersonal problems. For example, a physician whose uncle used anger to control her may now have problems with older men who similarly express anger. Another common situation is the practitioner who becomes very angry with patients who don't stop smoking. Possibly the physician in this case had a close relative whom he could not convince to stop smoking and who, as a result, developed lung cancer. Separating one's own past experience from a patient's current behavior can moderate the physician's aversive response.

The key to dealing with such situations is to examine them with a critical eye and a more flexible style of communication that includes considerable room for negotiation. Greater self-awareness about their own feelings, experiences, and beliefs can help prac-

titioners offer more nonjudgmental care to their patients. The case illustrations that follow focus on the situations practitioners most frequently find difficult and discuss specific approaches to these challenging patients and situations. Table 4-1 summarizes some general guidelines for working with difficult patients. Table 4-2 recommends techniques for approaching specific situations.

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### PATIENTS & PROBLEMS

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#### THE ANGRY PATIENT

*Case illustration 1:* When the doctor enters the room to see the fourth of the dozen patients scheduled for his Thursday morning session, his patient, Ms. B., a 35-year-old social worker, is sitting with arms crossed, refusing to make eye contact. The doctor greets the patient by asking, "Ms. B., how are you?" She responds, "I've been waiting 35 minutes! This is no way to run an office." The doctor, who is emotionally drained after spending the last 50 minutes working with a patient newly diagnosed with breast cancer, wonders why he's chosen medicine as a career.

#### Diagnosis

Even without this straightforward verbal response, an angry patient is not difficult to recognize. Harsh nonverbal communication such as stony silence, piercing stare, abrupt movements, a refusal to shake hands, gritting the teeth, and confrontational or occasionally abusive language provide unmistakable evidence. More subtle behaviors include the patient refusing to answer questions; failing to make eye contact; or constructing nonverbal barriers to communication such as crossed arms, turning away from the provider, or increasing the physical distance between them.

**Table 4-1.** General guidelines for working with difficult patients.

- Seek broader possibilities for the patient's emotion or problems.
- Respond directly to the patient's emotions.
- Solicit the patient's perspective on why there is a problem.
- Avoid being defensive.
- Seek to discover a common goal for the visit.

**Differential Diagnosis:** All too often, practitioners assume that the patient is angry with *them*, and, as a result, feel blamed for something they must have done or forgot to do. Although that is one possibility, other important reasons must be considered as the cause for anger. These include, but are not limited to the following (Table 4-3).

- Difficulty in getting to the office
- Problems with the office staff
- Anger directed toward the illness from which the person suffers
- Anger at the cost of health care
- Problems with consultants to whom the practitioner referred the patient
- Unanticipated problems from a procedure or medication recommended by the practitioner
- Previous unsupportive or condescending treatment by a physician
- Anger directed at family members' response—whether inadequate or overemotional—to the patient's illness

- Other significant news or problems unrelated to medical service, such as work- or family-related stress.

**Psychological Mechanisms:** Many patients view medical practitioners as “special” individuals who are supposed to be interested in the problems of their patients' experience. Patients expect to have their concerns investigated with compassion and interest. For many, this special relationship is among the best they experience in their lives, and it is therefore quite common for patients to express emotions they would never consider revealing—let alone discussing—with other relationships. Any suggestion that the patient's concerns are not taken seriously or that they are not cared for—that the doctor sees them as an aggregation of symptoms—may diminish that feeling of safety and replace it with anger.

Patients have lofty expectations of medical practitioners. They expect timely service, relevant information about evaluations and treatments offered, and advice on how to cope with their illness. Interactions that fall short can result in feelings of humiliation and rejection that can quickly turn to anger.

From the provider's point of view, the patient's expression of anger may trigger feelings as diverse as somehow having failed the patient or of being treated disrespectfully. In either case, common responses are defensiveness, expressed as anger returned to the patient, withdrawal from the relationship, or defense of the behavior that the practitioner *assumes* prompted

**Table 4-2.** Tips for approaching difficult situations or patient behaviors.

Situation	Recommended Techniques
Angry patients	Elicit the patient's reason for being angry: <i>You seem angry; tell me more about it.</i> Empathize with the patient's experience: <i>I can understand why you would be angry.</i> Solicit the patient's perspective: <i>What can we do to improve the situation?</i> If appropriate, apologize: <i>I'm sorry you had to wait so long.</i>
Silent patients	Point out the problem: <i>You're being very quiet.</i> Elicit the patient's reason for silence: <i>Why are you being so quiet?</i> Explain the need for collaboration: <i>In order for me to help you, I really need you to talk to me more about your problem.</i> Respond to cues of hearing impairment or language barriers: <i>Are you having trouble hearing or understanding me?</i>
Demanding patients	Take a step back from the demand: <i>You seem adamant about the MRI. Why do you think it's so important?</i> Solicit the goal of the demand: <i>Is there a particular problem you think the MRI will help us diagnose?</i> Acknowledge emotions unexpressed at the time of the demand: <i>It must be very frustrating that your back still hurts.</i> Solicit the patient's perspective: <i>What do you think is causing your problem?</i> <i>In what way had you hoped I could help you?</i>

Table 4-3. Possible causes of patient anger.

Cause	Discussion
Difficulty in getting to the office	<i>Take a second and relax; the construction on Highway 6 is a nightmare. . . .</i>
Problems with the office staff	<i>What happened? How could our people have been more respectful?</i>
Anger directed toward the illness from which the person suffers	<i>It must seem unfair. . . . I can understand how angry this makes you. . . .</i>
Anger at the cost of health care	<i>Empathize, then brainstorm alternative approaches.</i>
Problems with consultants to whom the practitioner referred the patient	<i>What was the problem—from your point of view? I appreciate knowing this.</i>
Anger at being unable to see a specialist	<i>Negotiate: How about your seeing a specialist if my treatment plan doesn't relieve your symptoms in 2 weeks?</i>
Misdiagnosis or dismissive treatment from prior physician	<i>I see. I hope you'll let me know if I do anything like that!</i>
Unanticipated problems from a procedure or medication recommended by the practitioner	<i>This is disappointing. Let's see if we can get a better response. . . .</i>
Anger directed at family members' response—whether inadequate or overemotional—to the patient's illness	<i>Would you like me to explain the situation to your mother? She may not understand the problem.</i>
Other significant news or problems unrelated to medical service, such as work- or family-related stress	<i>Acknowledge appropriately.</i>

the anger. The problems are magnified if the expression of anger is problematic in the practitioner's own family. After recognizing the contributions of one's own experiences, openly encouraging and confronting a patient's feelings creates and honest and open relationship, defines the problem explicitly, and permits an accurate and timely response.

### Management

In most situations involving anger, evaluation and understanding should also begin the therapeutic process. Responding calmly, without judgment or projection, with "You seem angry" tests whether the doctor has correctly identified the emotion. Failing to confront anger early keeps the interaction at a superficial level, informs the patient that the provider is impervious to or unsettled by emotion, and discourages any meaningful sharing of feelings. On the other hand, confronting anger is both efficient and medically appropriate.

Although many patients in this situation respond with, "You bet I'm angry," some patients deny their anger. Nonetheless, their body language or tone of voice betrays the emotion. In this case, the physician can address the denial: "Maybe 'angry' is too strong a word. It seems to me that you're upset by something; if you'd like to tell me about it, I might be able to help." The practitioner's invitation to explain offers the patient the chance to express his or her feelings, often leading to a discussion about the reasons for the patient's anger. As a result, the practitioner develops a more complete understanding of the causes and implications of the patient's experience of the health-care process. Armed with the patient's point of view and an accurate account of the patient's experience, the prac-

itioner and the patient can agree to focus on the problem. This point in the encounter is usually marked by a reduction in the patient's anger, relief on the part of the provider, and the re-creation of patient-doctor collaboration with the mutual goal of solving the identified problem. The subsequent management of the problem depends on the particular cause of the anger.

**Case illustration 1 (Contd.):** In response to the question, "Why are you angry?" Ms. B. responds, "The surgeon you sent me to wasn't prepared when I saw her and said that she hadn't received your letter. I had to take half a day off from work—which I could not afford—I drove 2 hours to get there, and all I did was waste my time. And now you keep me waiting when I'm due in court in an hour."

In response, the doctor apologizes, saying that the letter had been dictated but apparently not mailed in time and that the practice is purchasing a fax machine to allow more efficient communication. He also tells the patient that this morning's delay was unavoidable because of another patient's needs. Ms. B. feels better understood, accepts the apology, and ends by saying, "I hope this doesn't happen again; I have enough stress at work as it is." The doctor says, "I should have asked the receptionist to tell you that I was running late—I'm sorry about that. We're really trying hard to make sure that we communicate more effectively with our patients and our consultants." The total exchange takes 50 seconds—a time cost that is certainly worthwhile.

### Patient Education

Sometimes, patients need to learn that it is not only permissible but important for them and their families to express their feelings. By encouraging the expression of anger, the practitioner helps identify unresolved

conflicts that can interfere with the process of delivering appropriate care or can, if ignored, cause far more serious problems later. Encouraging patients and their families to express concerns or disappointments actually offers the practitioner the opportunity to become more efficient by removing significant barriers to effective, honest collaboration. The use of this approach by the office and nursing staff extends the environment in which patients feel respected, further increasing their willingness to share thoughts, concerns, and ideas.

### Summary

Too often we assume that angry patients are simply angry with the practitioner. Sometimes this is so, but there is usually a much broader and more complex range of reasons for anger that must be explored prior to responding emotionally, offering an explanation, or creating a treatment plan. By working hard to avoid becoming defensive, practitioners can acknowledge and then constructively resolve the cause of the anger. Confronted with such a responsive approach, most angry people become quite satisfied and resume effective collaboration in their care.

## THE SILENT PATIENT

*Case illustration 2:* The doctor begins her afternoon office hours scheduled to see Mr. K., a 47-year-old man who has recently relocated to the area. On entering the room, the doctor is aware that Mr. K. fails to make eye contact and fiddles with a piece of paper folded over many times. In response to "Good afternoon; I'm Dr. W.," Mr. K. quietly says, "Good afternoon." When asked what problems he is having, Mr. K. answers, "I've been really tired." After waiting a few seconds, Dr. W. encourages the patient to speak by asking him to tell her more. The patient responds, "I don't know what to say."

### Diagnosis

By definition, the silent patient offers little verbal interaction in the interview. In addition to the lack of communication, however, there are a number of important nonverbal cues that deserve attention. The patient may seem withdrawn, as indicated by sitting a greater distance from the physician than usual, failing to make eye contact, avoiding the physician's gaze, seeming distracted, or not acknowledging the physician's attempts at interaction. Alternatively, the patient may seem anxious, evidenced by nervous or repetitive habits such as nail-biting, pacing, or folding and refolding papers. Finally, the patient may seem sad with deep sighs, red eyes, or tears.

**Differential Diagnosis:** Based on the observation of the patient and the responses to questions, one might consider the following bases for the silence (Table 4-4):

- Anger
- Fear of the physician's authority

- Fear of serious disease causing the presenting problem
- Depression, dysthymia, or adjustment disorder with depressed mood
- Adverse effects of psychoactive medications
- Preoccupation with auditory or visual hallucinations
- Hearing impairment
- Passive personality
- Cultural or language barriers
- Forced by third party (rehabilitation program, court, spouse, nursing home) to be at the visit.

**Psychological Mechanisms:** In many families, individuals in positions of authority may demand "silence unless spoken to," a demand whose effects frequently carry over into other situations. This dependence of silence may also be found in interactions in which a significant difference in gender or social class exists (whether real or perceived) or a previous history of mistreatment in medical or cultural encounters occurred.

When a patient has a serious or potentially life-threatening basis for concern, silence may indicate denial or serve as a protective behavior. For example, a patient can avoid confronting her fears about breast cancer if she does not mention feeling a breast lump while in the shower.

Silence may also be a common behavior in individuals who are described as having passive personalities. These individuals want the partner in the interview to take control and direct the flow of the visit (see Chapter 25). Finally, silence may be a profound indicator of a depressed mood with psychomotor retardation or an adverse effect from a sedative medication. Those struggling with depression or dysthymia may find it difficult to express their concerns or even initiate conversation.

### Management

It is often helpful, when confronted with a patient who finds it difficult to speak, to address the behavior by saying, "You seem very quiet." This offers the patient the opportunity to acknowledge the behavior and express the reason. It is valuable to provide a significant amount of time, at least 3-5 seconds, for the person to respond to this reflection. When a patient seems passive, it is appropriate to explain the need for the patient to collaborate in the visit: "In order for me to help you, I really need you to tell me about this problem in more detail."

If the person seems actively distracted, it is fair to ask, "Are you hearing voices or seeing things you think might not be real?" If the patient gives evidence of anger, reflecting the emotion would be appropriate (as described earlier). Especially with older patients, if the patient responds with "What?" one has most likely diagnosed a hearing impairment and need only speak louder face-to-face. One of the most common complaints by older patients is that their providers don't speak clearly or loudly enough.

Table 4-4. Possible causes of silence in patients.

Cause	Discussion
Adverse reaction to prescription medication (eg, sedation)	Check for overdose or drug interactions.
Alcohol or other drug intoxication	Screen with CAGE questionnaire and elicit history of substance abuse.
Alzheimer's or other dementia	Age-dependent; although some dementias strike as early as the mid-40s, most occur in the 66+ age group. Silence is usually a sign of advanced disease associated with withdrawal from the environment.
Anger	The patient is feeling wronged or slighted and is trying to elicit an emotional reaction. . . . (see Table 4-3).
Cultural or language barrier	Ask whether patient can understand; use interpreter or bilingual staff member, if available.
Depression, dysthymia, or adjustment disorder with depressed mood	Name the feelings; request elaboration.
Distraction secondary to depression	Associated with drawn features, sad affect, lack of eye contact.
Fear of being told that serious disease is causing the presenting problem	State clearly that, regardless of the outcome, the practitioner will be there to help.
Fear of physician authority	Family background, other experience with domineering authority figures may have demanded submissiveness; a gentle demeanor, reassurance, and an explicit request for collaboration can help win the patient's confidence.
Hearing impairment	Use whisper test.
Passive or shy personality	Change to a more direct, closed-ended pattern of questions; encourage descriptions and elaboration.
Preoccupation with auditory or visual hallucinations	Request additional information from family or attendant.
Quiet person	Usually responds to encouragement, offers to elaborate.
Stroke, TIA (transient ischemic attack), mass lesion	Conduct thorough neurologic examination for focal findings.

**Case illustration 2 (Contd.):** In response to "You seem quiet," Mr. K. responds, "Today is 3 months since my favorite aunt died." When the provider says, "I'm sorry to hear that; would you like to reschedule the visit?" the patient thanks her for the offer, adding that he's concerned about the fatigue and would like to talk about it. With that, the patient becomes more animated and engages in the discussion about his fatigue, which is subsequently diagnosed as being a symptom related to depression.

### Patient Education

By explaining to patients that their silence creates additional barriers to the delivery of effective care, barriers that must be overcome, physicians can invite patients to collaborate and to make decisions about their own care. Emphasizing the importance of the patient's or family member's role in evaluating and treating problems underscores the value of participation. It also discourages the patient from making the practitioner solely—and inappropriately—responsible for evaluation or treatment.

### Summary

Obviously, there are many reasons why individuals might be silent in the office. Acknowledging, in an open-ended way, the problems silence creates, and then

asking for an explanation offers the patient the chance to express a feeling state, an extenuating circumstance, fear of an outcome, or fear of the projected role of the practitioner. Further questioning can also result in the diagnosis of a physical disability like acoustic neuroma or a psychiatric condition that causes hallucinations or delusions that make a response impossible. Premature hypothesis testing runs the risk of insulting patients or driving them further from the relationship.

Silent patients are always distressing, particularly for individuals who particularly value the social dynamic and satisfactions of medical practice. Learning to encourage a more mutual collaboration is usually beneficial and rewarding when specific causes for unusual degrees of silence are discovered and overcome. It is interesting that sometimes the reason for struggling with particular types of patients is that they remind us of others from previous experiences who evoke strong negative responses. For example, someone easily frustrated by silent patients may be reminded of a parent who died because he didn't let anyone know he was having chest tightness. Recognizing the sources of our personal intense responses can be most helpful in assisting practitioners to remain focused on a patient's problem or response and avoid unproductive replays of unsettling experi-

ences from the past. Acknowledging the power of these prior experiences allows the practitioner to decide how to confront or address these important personal issues.

## THE DEMANDING PATIENT

**Case illustration 3:** The doctor is seeing Mr. G., a 48-year-old bricklayer, her fifth patient of the afternoon, for follow-up of his back pain that began after a day of particularly heavy work on the job. In the initial visit, after excluding historical points suggestive of an underlying cancer or spinal cord injury, the doctor prescribed limited activity, exercise as tolerated, analgesics, and the application of heat. Two weeks later, Mr. G. returns, and when asked how things have gone in the last 2 weeks, responds, "I'm no better and I want an MRI today." The doctor leans back in her chair, anticipating an extremely frustrating encounter.

### Diagnosis

When a demand is made, the practitioner may quickly identify the signs of anger. Alternatively, the patient's actions—nail-biting, repetitive movements, or poor attention—might suggest frustration or anxiety. A grimacing facial expression, an inability to move, or obvious pain with movement suggests greater-than-anticipated pain. A focus on a seemingly unrelated article—a medical device like a cane or brace, a magazine article, or an advertisement—can reveal a concern directly or indirectly related to the item on which attention is focused.

**Differential Diagnosis:** Although a patient's demand is usually tied to dissatisfaction with the current plan for evaluation or treatment, there are many possible causes of the dissatisfaction. As a rule, if there is disagreement about treatment, the problem results from a concern about the accuracy of the diagnosis. If the problem involves a diagnostic test, the problem often arises either in the prior evaluation or a failure to solicit important aspects of the history. On the other hand, a recommended test or treatment may remind the patient of a similar and unpleasant experience among family or friends, causing the patient to anticipate a similar undesirable outcome.

Sometimes the reason for an unexpected demand involves secondary gain, such as a workers' compen-

sation claim, a lawsuit, or disability income. Another possibility is that the patient has seen something in the press, listened to a radio broadcast, or seen something on television that suggests a simplistic "right" way to solve the problem while attacking other approaches. More and more often in a managed care settings, the patient also may be concerned that the practitioner is withholding a more expensive test or treatment in order to limit cost—at the expense of quality medical care. The demand then becomes part of the anticipated struggle to wrestle needed service from the gatekeeper practitioner (see Chapter 7). Finally, it must be remembered that the patient may be frustrated with the lack of relief because additional treatment is actually indicated. The patient's dissatisfaction can prompt the practitioner to rethink the diagnosis and seek appropriate alternatives to the current treatment plan. An example would be the patient presumed to have a sprained wrist, who returns with unremitting pain. The increased severity of symptom reporting prompts a search for a fracture—which is subsequently diagnosed by x-ray.

**Psychological Mechanisms:** The demand for additional intervention can be triggered by any of the following feelings (Table 4-5):

- Anger
- Fear
- Frustration
- Doubt

Individuals are often isolated from family and friends during times of illness. The isolated person may begin to doubt that the practitioner is sufficiently interested in the problem to ensure the best possible outcome. As distrust of the physician grows, the patient feels increasingly responsible for the outcome of his or her care and, therefore, becomes both more fearful and more demanding. On the other hand, if secondary gains are connected with the illness, the patient may demand testing to demonstrate levels of disability or prove that the problem is as severe as claimed. This is especially true in pain syndromes in which testing is generally unrevealing, and the patient, the family, or the employer begins to feel that

Table 4-5. Possible reasons for demanding additional interventions.

Feeling	Discussion
Anger	The patient is feeling wronged or is reexperiencing a previous bad outcome (see Table 4-3).
Fear	The patient may be afraid that the illness is terminal, serious, horrible, disfiguring, etc., if not attacked quickly.
Frustration	The patient may feel that no—or insufficient—progress has been made.
Personal responsibility for health outcome	Previous experience may have convinced the patient that physicians are not trustworthy, competent, or interested.
Doubt	The patient may wonder if economic reasons are driving decision making or if the practitioner is skilled enough or up-to-date with current evaluation and treatment technologies.

the problem is "all in the patient's head." As a result, the patient seeks evidence of a severe condition capable of causing such problematic symptoms.

A demanding patient often provokes feelings in the practitioner of rejection, distrust, blame, or humiliation. As a result, the practitioner is often defensive, assuming reasons for the demand that may not be accurate. By assuming a defensive posture, the practitioner loses the opportunity to recognize the patient's subtle clues to the reasons for a demand. For example, casual asides; postural shifts in response to a topic; and expressions of fear, agitation, and grief are easily ignored.

### Management

Rather than respond to a presumed cause for the demand, the first step in evaluating or reevaluating the demand is to appropriately identify and explore the patient's affect. Let us consider case illustration 3. Because Mr. G. seems frustrated, the doctor reflects the feeling: "You seem frustrated." The patient responds, "I am frustrated. My father had a similar condition, and 2 years later they found he had a herniated disk. I don't want to wait that long to find out what I have."

In response to an acknowledgment of affect, the patient usually confirms or denies the practitioner's hypothesis. If the patient responds affirmatively (eg, "I am angry, frustrated, sad, nervous"), the practitioner would ask, "Why are you. . . ." This permits the patient to explain and share the experience that surrounds the emotion. Often, this prompts a story or a piece of information that is instrumental in allowing the physician to ask and the patient to answer pertinent questions. In Mr. G.'s case, hearing what the patient fears better prepares the practitioner to understand what prompted the request for an MRI and determine to what extent education, a redescription of the results of evaluation or treatment, another examination, or confrontation about possible secondary gain might be most appropriate. In this way, all aspects of a demand are explored and an appropriate response initiated.

When this approach is less successful, a number of probing questions are useful. One is to ask patients what they think is causing their problem; often patients do not offer their opinions without being asked. Given the opportunity, patients frequently say that after an evaluation they were told the test results were all negative, but the cause of the problem they perceived was not addressed. This point cannot be stressed enough: *In order to provide meaningful reassurance, the patient's attribution for the symptom must be elicited and confronted.*

Another useful question is: "How had you hoped I could help you?" This gives the patient the opportunity to express dissatisfaction with the extent of evaluation, treatment, or commitment by the practitioner; it often lightens the practitioner's burden, since the patient's request may be significantly less difficult than what the practitioner anticipated. A typical example might be the arthritic patient who complains

bitterly about the pain in his hip. When the physician asks, "How had you hoped I could help you?" the patient responds, "I'd like a prescription for a cane." The physician had anticipated a request for a hip replacement.

**Case illustration 3 (Contd.):** In response to the doctor's question, Mr. G. says, "I want to know how I can find out exactly what I have and make sure I don't have any problems with my disk." The doctor then describes the recently developed guidelines that support the use of MRI testing only for determining operability in patients with defined neurologic syndromes, such as radiculopathy and cauda equina syndrome.

By offering alternatives to the demand that would accomplish the same goal—while taking into account the patient's reason for the demand—the practitioner has begun the process of negotiation. Respect for the patient's point of view generally provides the basis for construction of a mutually satisfactory plan.

The doctor further explains to Mr. G.: "I've examined you again and I find no evidence of nerve root involvement. From what you've said about your father's symptoms, his back problem was quite different from what you're experiencing. Let's put off doing any tests for now. What I would like to do is continue our present course of treatment, since in 90% of cases the symptoms you describe resolve within 12 weeks. If at the end of that time you're still having these symptoms, I'll refer you to a neurologist for another opinion on what we might do. I appreciate your telling me about your dad because it's obviously causing you some distress and making you wonder whether I was doing the right thing. Looking at things from your perspective helps me do a better job." The time cost of this explanation is 33 seconds; the reexamination adds only 2 minutes.

It may appear to the practitioner that the demand is related to secondary gain (for example, a desire to remain away from work for an extended period). In that case, the practitioner can confront the patient and offer a plan that provides ample time for recovery, within a timeframe that is also acceptable to the practitioner and that sets reasonable boundaries for the practitioner's agreement to the demand.

### Patient Education

Patients respond to instruction when they believe it will be helpful in solving their problem. Until there is an agreement on the need for education by practitioner and patient, the patient might perceive education as the practitioner's way to control the visit, ignoring or masking a failure of collaboration. The patient's usual response in such an encounter is either to tune out the information or to construct mental barriers to implementing the practitioner's recommendations. On the other hand, once the patient's concerns have been addressed and the alliance has been formed, the patient often asks for and benefits from the information supporting the practitioner's point of view. In case illustration 3, recent guidelines that support the doctor's

plan serve to educate and reassure the patient that the plan is consistent with his best interests.

### Summary

A patient's demands can serve as a focal point for understanding when an interaction has been unsuccessful. Exploring the cause of the demand in a non-judgmental fashion allows most demands to be both understood and addressed. A plan that is mutually agreeable to practitioner and patient can then be negotiated. When it becomes clear that such a negotiation is not possible, the patient should be informed of realistic limits on what the practitioner can offer. The patient can then decide whether he or she is willing to accept the practitioner's boundaries or needs to seek the services of another practitioner.

### THE "YES, BUT . . ." PATIENT

**Case illustration 4:** Mrs. M. is a 58-year-old woman who is being followed for obesity and poorly controlled high blood pressure. Her doctor is frustrated because his continued attempts to get Mrs. M. to lose weight have been unsuccessful. As a result, he is frustrated and pessimistic about their ability to work together to treat her hypertension, which he feels is a clear risk to her health. When the doctor notes that Mrs. M.'s blood pressure is still elevated, he asks whether she is still taking her medication.

She responds, "Oh, I'm sorry doctor, I ran out of my medicine 3 days ago and didn't want to bother you for a refill." Later in the visit the doctor asks, "Did you join that exercise program you said you would last time?" Mrs. M. replies, "I've been so busy. I'll do it next week." The doctor pulls back in his chair, thinking to himself, "This will never go anywhere."

### Diagnosis

When problems are being discussed, the nonverbal behavior of patients in this group usually involves an active posture: leaning forward, bright affect, and dynamic gestures. As recommendations for evaluation and treatment are made, however, the patient typically becomes withdrawn, eye contact diminishes, and language becomes significantly less animated. Verbally, during the discussion of evaluation and treatment, the patient becomes quiet, volunteers little, and characteristically offers no solutions to problems. In fact, as the practitioner makes recommendations, the patient often responds with the classic, "I'd like to do that but. . . ."

**Differential Diagnosis:** Frequently, this behavior indicates a passive-aggressive personality. The practitioner initially feels encouraged to explore and offer suggestions to the patient—who then invariably rejects the offer or agrees to the plan but does not carry it out.

There are other possibilities, however, that are often not explored. Probably most important is that the

practitioner's plan has not taken the patient's perspective into account and is therefore unrealistic or is economically or logistically impossible. Another consideration is that the patient comes from a highly controlling family and is attempting to follow the recommendations but is unable to for psychosocial reasons. Another, similar possibility is that the patient's previous experiences with practitioners may have been so hierarchical and paternalistic that the thought of disagreeing or negotiating a position with a practitioner does not come to mind.

**Psychological Mechanisms:** Passive-aggressive behavior is often a form of control used by persons who do not feel capable of asserting themselves directly. They may become skilled in positioning themselves so that others feel they want to—or must—save them, frequently on a long-term basis. The practitioner's attempt to solve the problem is invariably followed by the patient's frustrating failure to collaborate. Continued failure results in the need for repeated visits, thus offering the desired outcome of frequent ongoing attention (secondary gain rather than healing).

Other patients who are unable to offer an opinion may have been emotionally, verbally, or physically abused earlier in life or may have had family or other personal experiences that taught unquestioning submission to authority.

Most people who enter the healing professions have a desire, even a need, to be of help. The solicitation by passive-aggressive patients for the practitioner to save them can be extremely seductive, luring practitioners into believing that these patients will specially benefit from their expertise. The extent to which practitioners use a patient's recovery to validate their competence or professional value may determine how frustrated and angry they will become when treatment is unsuccessful. Rather than focusing initially on outcomes, the physician is better served answering the questions "Am I encouraging patients to take a more active role in their care?" and "Am I giving patients the chance to say why they're not using the treatments I thought we agreed on?"

### Management

In working with individuals who apparently need to have the practitioner solve their health problems, it is important to remember (and to remind the patients) that ultimately only they themselves can do so. To help differentiate patients who are dependent and unable to carry out plans from those with a definable personality disorder, the physician can confront the patient and offer, "I'm frustrated with how things are going. Let's start again and see if what I see as a problem is really a problem for you."

Agreement on the diagnosis of the problem initiates the sequence for treatment. If there is disagreement, such questions as "What do you think the problem



is?" or "What do you think should be done?" should be asked explicitly. If agreement is not reached, practitioner and patient must work to resolve the conflict.

If the patient agrees with the problem statement, the next step is to ask what he or she thinks would be helpful in solving the problem. Again, to distinguish patients who are unable to collaborate successfully from those who have a personality disorder, one can ask, "Do you think you can really do this?" If the question is asked in a supportive fashion, many patients who initially agreed to an unrealistic plan (perhaps to please the practitioner), respond more honestly, acknowledging that they are unable to participate. If asked respectfully, they generally explain their reasons. Once the patient has been truthful, the practitioner can encourage collaboration by saying, "Let's explore what we can do to solve this problem together. It will certainly help if you tell me what's possible for you and what's not." The approach to patients with personality disorders, which is beyond the scope of this chapter, is covered in Chapter 25.

If the patient displays passive-aggressive behavior, the practitioner can seek agreement on the nature of the problem and then make very specific contracts for what the patient will do. They can be as simple as "So, until our next visit, you will remain abstinent from alcohol," or "Between now and our next visit, you'll keep a diary and record when, and under what conditions, your headaches occur." The physician's support and enthusiasm can be directly tied to the degree to which both parties carry out the requirements of the contract. In this way, the physician can promote the patient's autonomy and offer support, without taking full responsibility for the patient's behavior. Over time, patients learn to respond to the support offered and begin to take a more active role in their care. Of course, there is the risk that a passive-aggressive individual attempting to control the relationship will seek another practitioner who can be more easily controlled.

### Patient Education

Patients who are unfamiliar with a collaborative model can be given specific information about the practitioner's understanding and particular style of collaborating. Explicit requests for patients' opinions about doctor-patient collaboration can be extremely useful. Over time, given the opportunity to state opinions and formulate plans, most individuals find such an approach satisfying and engaging. Indeed, there is convincing evidence that patients taught to be more assertive improve their health outcomes, such as lowering blood pressure and controlling diabetes.

Educating patients who exhibit passive-aggressive behavior about such behavior can begin a process of introspection and self-awareness. Encouraging individuals to explore the origins of these behaviors and also to consider a therapeutic relationship to facilitate the process can be rewarding for both patient and practitioner. Descriptions of behavior that hit home can

provoke emotional responses in patients, but penetrating long-held psychologic defenses can spur growth. The physician might say, for example, "You say your mother was overbearing and controlling and withheld praise. Isn't that what your children are telling you?" In most instances, the benefits outweigh the risks.

*Case illustration 4 (Contd.):* The doctor leans forward and says, "Mrs. M., your actions tell me I'm pushing you to do something you don't want to do. I'm concerned about your weight—what are your thoughts on this?" Mrs. M.'s eyes moisten and she responds, "I want to lose weight, but I can't do it. I've tried for years, and it's so frustrating." The doctor nods and says, "Let's hold off on the weight control for now. How about taking one thing at a time and focusing on your blood pressure?"

Mrs. M. agrees to take her medication and to return for a blood pressure check in 2 weeks. The doctor gives her a card so that she can record her own blood pressure when she checks it at the drug store or the mall.

### Summary

Setting limits and providing explicit feedback can teach patients to collaborate more effectively in their care. Being aware of yes-but patterns can help the practitioner initiate a strategy to develop shared responsibilities that prevent the ultimately unhelpful rescuing behaviors that leave all parties frustrated and dissatisfied and that interfere with successful treatment.

### INDICATIONS FOR REFERRAL

Indications for referral of individuals whose interactions are difficult include the practitioner's inability to make a diagnosis, negative personal feelings that create a barrier to a therapeutic relationship, an objective assessment that the patient is not benefiting from evaluation or treatment, or the practitioner's feeling of being threatened or in danger.

With particular reference to a practitioner's negative feelings, when an inability to work together significantly impairs the provision of effective care, outside assistance and advice are not only desirable but may also be cost-effective. Since the negative feelings can relate to a practitioner's previous family and life experiences, a patient who is difficult for one physician may not be difficult for another.

Once the decision to refer is made, framing the referral in a positive way is particularly valuable. One strategy is to acknowledge the need for assistance in managing difficult situations or problems. The dialogue might take the following form:

DOCTOR: Mrs. S., for the last 2 months I've been trying to figure out how to make your headaches better. I think it would help us if you could be evaluated by a psychologist; we might be able to get a better handle on what else we could do to deal with the problems.

Mrs. S.: Are you saying that I'm imagining this? Do you think it's all in my head?

DOCTOR: No, not at all. But nothing we've tried has stopped your headaches. It often helps me to have another person listen to the story and maybe find a new direction to take. Dr. F. has helped me with a number of people in the past, and I'm hopeful she can help us here as well.

Mrs. S.: What do I have to do? I really do want these headaches to end.

DOCTOR: Great. In addition to the referral, I'll schedule you for three visits with me over the next 12 weeks to see how things are going and help answer any questions you or Dr. F. may have.

Proposing a positive outcome from the referral can be remarkably useful. In addition, scheduling a visit for the person to return after the referral reassures the patient that the referring physician is truly seeking assistance rather than simply "dumping" the problem on someone else.

Learning to understand the person's perspective, negotiating for realistic plans of evaluation and treatment, and being aware of and responsive to verbal and nonverbal evidence that a recommendation was understood or rejected creates a collaboration that can be remarkably satisfying for both participants.

Underused skills such as soliciting the patient's attribution for a problem, offering praise and support, listening carefully to the patient's description of a problem, and explicitly confronting problematic or confusing behavior inform the patient that a serious attempt is underway to understand and work with the patient's concerns.

By exploring their own expectations and feelings, practitioners become more self-aware and recognize who else is in the room. Clearly, to the extent practitioners improve their self-awareness and learn to confront their feelings, their effectiveness as physicians will improve.

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# Behavioral Medicine in Primary Care

## *A Practical Guide*

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## INTRODUCTION

Establishing successful relationships with patients who are suffering from personality disorders can be quite challenging for health-care providers, yet these patients are common in medical practice. Patients with personality disorders may over- or underuse medical care, and they often have more difficulty complying with treatment. In addition, these patients are more likely to be hospitalized. An understanding of personality disorders allows physicians to anticipate the challenging interpersonal and behavioral problems that can arise in working with these patients. This knowledge can help physicians to work through the negative emotions that working with such patients may arouse, thereby facilitating the development and implementation of appropriate treatment plans.

The current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines personality disorder as

... an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

People suffering from personality disorders are affected in their view of themselves, their ability to establish and maintain relationships with others, and their ability to function at work and to experience pleasure in life. These patients have difficulty negotiating complex situations and coping with stress and anxiety. The sick role and the demands of medical care can be particularly problematic for them. The stress of illness is often extreme and sets into motion defensive and inflexible emotional processes, cognitions, and behaviors—with negative consequences for their medical treatment. In addition, these patients' difficulties in relating to others manifest themselves

in the doctor-patient relationship. They may be quite demanding or disrespectful of the needs of others, or they may experience such anxiety when needing to trust or confide in others that they may avoid building relationships.

Personality theorists have long debated how best to understand and classify personality disorders. The debate has centered on two models. The **categorical model**, adopted by *DSM-IV*, views personality disorders as entities that are distinct from one another—that is, classified in separate categories—and also distinct from normalcy. This model blends more easily with traditional medical diagnosis than does the **dimensional model**, which views personality disorders as overlapping with each other and with normalcy, so that the maladaptive traits of patients with personality disorders represent normal traits that are exaggerated.

In fact, both models hold some truth. Some personality disorders, such as schizotypal and paranoid, may belong to a spectrum of illness that includes psychotic Axis I disorders and are thus better explained by a categorical model. Other personality disorders, such as histrionic and obsessive-compulsive personality, may depict exaggerated normal traits, reinforcing the concept of a dimensional model.

## Diagnostic Classification of Personality Disorders

*DSM-IV* classifies personality disorders on a separate axis, Axis II, and groups them into three clusters based on descriptive similarities. Cluster A includes paranoid, schizoid, and schizotypal personality disorders—individuals who often appear odd or eccentric; cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders—individuals who often appear dramatic, emotional, or erratic; and cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders—individuals who often appear anxious or fearful. Given the unique nature of any individual personality, a patient can exhibit

traits of two or more personality disorders, or meet the full diagnostic criteria for more than one disorder.

Diagnosing a personality disorder can be a difficult task. In order to make an accurate diagnosis, it is usually necessary for the physician to get to know the patient over time, to find out how the patient reacts in other situations, and to obtain collateral information from family and friends. Clinicians should attend to three key issues.

First, it is important to differentiate a true personality disorder from personality traits that become exaggerated under stress. The stresses of illness on the patient often cause illness, and patients often behave in a more dependent or childlike manner within the doctor-patient relationship; because of this, many patients, at one time or another, may seem to have a personality disorder. Patients who do not suffer from a true personality disorder, however, are usually capable of more adaptive functioning. In these cases, the physician can successfully intervene by supporting and strengthening the patients' own natural coping skills.

Second, it is also important to differentiate personality disorders from such Axis I disorders as major depression or generalized anxiety disorder. For example, a patient with panic disorder may—out of sheer terror—become extremely dependent on her physician. If her panic disorder is diagnosed and treated, she may reveal an underlying, independent, and self-sufficient personality. When evaluating patients who do have a personality disorder, look carefully for the presence of an Axis I disorder, since if they actually have a personality disorder, the latter disorders are more frequent and difficult to treat in these patients. Treating an episode of major depression in a patient with borderline personality disorder, however, can alleviate suffering and lead to better coping with illness.

Third, the primary care provider must distinguish personality disorders from personality changes caused by general medical conditions, such as head trauma, stroke, epilepsy, or endocrine disorders. Patients with one of these problems may exhibit many of the characteristics of a personality disorder. These behaviors can be distinguished from a true personality disorder, however, in that they typically represent a change from baseline personality characteristics. Medical conditions such as these at times may also exacerbate preexisting personality traits (eg, obsessive mannerisms). Treatment of the underlying medical problem may bring about reversal of the personality changes.

Finally, personality disorder diagnoses, like other mental disorder diagnoses, are often misunderstood and may serve to stigmatize the patient. These diagnoses should therefore be made carefully, deferred in cases of uncertainty, and noted in medical records and correspondence only when they are likely to be helpful in enhancing patient care.

### Doctor-Patient Relationship Issues

The primary care provider may find many challenges in working with patients with personality disorders. Personality disorders often significantly impair the quality of interpersonal relationships. Since the doctor-patient relationship requires effective communication about important health issues of a personal nature, tensions, and—at times—overt conflict, may develop between patients with personality disorders and their providers. These tensions may also affect other members of the health-care team and may be especially pronounced in the context of acute illness or crisis situations. In fact, the first diagnostic clues suggesting personality dysfunction, or disorder, may appear as difficulties in the doctor-patient relationship.

For patients with personality disorders, physical illness can cause exaggerated degrees of emotional distress, which is not always expressed to the provider. Although some patients do tell their providers about their emotional distress, others may instead exhibit the distress as statements about emotional distress, or it may appear as changed, unexpected, or undesirable behavior (as judged by the physician) toward the physician. Alternatively, expression of emotional distress may manifest as noncompliance with the agreed-on plan of evaluation or treatment.

Physicians are likely to become aware of patients' expression of distress, whether through the patients' actions or statements. This expression of distress may result in physicians having a significant emotional reaction to these patients, possibly leading to change their behavior toward the patients. Even when they experience no subjective distress from a medical condition or the doctor-patient relationship, patients with personality dysfunction may have such aberrant expectations of others that their statements or behavior are troubling or burdensome to the physician. Physicians must be aware of their own emotional responses to such patients so as to avoid reacting inappropriately. Physicians who deny their negative feelings toward the patients may fail to recognize a personality disorder or other psychiatric diagnosis, or fail to address the diagnostic and treatment needs of the patient with the necessary vigor and thoroughness. When clinicians recognize and deal with their negative feelings, they are better able to make thoughtful and appropriate responses to these patients' psychological symptoms and behavior, minimizing the emotional strain for both patient and doctor and optimizing the quality of the medical outcome.

A clear understanding by both patient and doctor of the role each expects the other to play can aid in identifying problematic behaviors and can help to maintain the necessary degree of cooperation and collaboration, even when the patient has significant personality dysfunction. In this regard, it is important to understand how patients with different personality disorders vary in their needs and expectations

**Table 25-1.** Common personality disorders and typical manifestations

<b>Personality Disorder</b>	<b>Paranoid</b>	<b>Schizoid</b>	<b>Antisocial</b>	<b>Borderline</b>
<b>Prominent features of disorder</b>	Distrust and suspiciousness of others, such that their motives are interpreted as malevolent	Pattern of detachment from social relationships and a restricted range of emotional expression	Disregard for and violation of the rights of others, beginning in adolescence	Pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity
<b>Patient's experience of illness</b>	Heightened sense of fear and vulnerability	Threat to personal integrity; increased anxiety because illness forces interaction with others	Sense of fear may be masked by increased hostility or entitled stance	Terrifying fantasies about illness; feels either completely well or deathly ill
<b>Problematic behavior in the medical care setting</b>	Fear that physician or others may harm them Misinterpretation of innocuous or even helpful behaviors Increased likelihood of argument or conflict with staff	May delay seeking care until symptoms become severe, out of fear of interacting with others May appear detached and unappreciative of help	Irresponsible, impulsive, or dangerous health behavior, without regard for consequences to self or others Angry, deceitful, or manipulative behavior	Mistrust of physicians and delay in seeking treatment Intense fear of rejection and abandonment Abrupt shifts from idealizing to devaluing caregivers; splitting Self-destructive threats and acts
<b>Common problematic reactions to patient by caregiver</b>	Defensive, argumentative or angry response that "confirms" patient's suspicions Ignoring the patient's suspicious or angry stance	Overzealous attempts to connect with patient Frustration at feeling unappreciated	Succumbing to patient's manipulation Angry, punitive reaction when manipulation is discovered	Succumbing to patient's idealization and splitting Getting too close to patient, causing overstimulation Despair at patient's self-destructive behaviors Temptation to punish patient angrily
<b>Helpful management strategies by caregiver</b>	Attend to and be empathic toward patient fears, even when irrational in appearance Carefully detail care plan for patient with advance information about risks of procedures/treatments Maintain patient's independence when possible Professional, but not overly friendly stance	Appreciate need for privacy and maintain a low-key approach Focus on technical elements of treatment; these are better tolerated Encourage patient to maintain daily routines Do not become personally overly involved or too zealous in trying to provide social supports	Carefully, respectfully investigate patient's concerns and motives Communicate directly; avoid punitive reactions to patient Set clear limits in context of medically indicated interventions	Don't get too close to patient Schedule frequent periodic check-ups Provide clear, non technical answers to questions to counter scary fantasies Tolerate periodic angry outbursts, but set limits Be aware of patient's potential for self-destructive behavior Discuss feelings with coworkers and schedule multidisciplinary meetings

(continued)

in this relationship. Table 25-1 outlines typical responses to illness by patients with each of the most common personality disorders, details troublesome reactions by physicians, and suggests strategies to avoid further problems with these challenging patients. (Avoidant and schizotypal personality disorders are not included in the table—or discussed in this chapter—because of their relative rarity in primary care practice.)

### Management of Patients With Personality Disorders

In most cases, a stable therapeutic alliance with patients who have personality disorders can be maintained by implementing the behavioral strategies suggested in the following sections. Sometimes other factors must also be addressed. As mentioned earlier, comorbid Axis I diagnoses (eg, depression, anxiety disorders) must be treated. The most common exam-

Table 25-1. Common personality disorders and typical manifestations. (cont.)

Personality Disorder	Histrionic	Narcissistic	Dependent	Obsessive-Compulsive
Prominent features of disorder	Pattern of excessive attention-seeking and emotionality	Pervasive pattern of grandiosity, need for admiration, and lack of empathy for others	Pervasive and excessive need to be taken care of that leads to submissive and clinging behavior, and fears of separation	Pattern of preoccupation with orderliness, perfectionism, control
Patient's experience of illness	Threatened sense of attractiveness and self-esteem	Illness may increase anxiety related to doubts about personal adequacy	Fear that illness will lead to abandonment and helplessness	Fear of losing control over bodily functions and over emotions generated by illness; feelings of shame and vulnerability
Problematic behavior in the medical care setting	Overly dramatic, attention-seeking behavior, with tendency to draw caregiver into excessively familiar relationship Inadequate focus on symptoms and their management, with over-emphasis on feeling states May provide answers they believe physician wants to hear Tendency to somatize	Demanding, entitled attitude Excessive praise toward caregiver may turn to devaluation, in effort to maintain sense of superiority Denial of illness or minimization of symptoms	Dramatic and urgent demands for medical attention Angry outbursts at physician if not responded to Patient may contribute to prolong illness or encourage medical procedures in order to get attention May abuse substances and medications	Anger about disruption of routines Repetitive questions and excessive attention to detail Fear of relinquishing control to health-care team
Common problematic reactions to patient by caregiver	Performing excessive work-up (when patient is dramatic) or inadequate work-up (when patient is vague) Allowing too much emotional closeness, thereby losing objectivity Frustration with patient's dramatic or vague presentation	Outright rejection of patient's demands, resulting in patient distancing self from caregiver Excessive submission to patient's grandiose stance	Inability to set limits to availability, thus leading to burnout Hostile rejection of patient	Impatience and cutting answers short Attempts to control treatment planning
Helpful management strategies by caregiver	Show respectful and professional concern for feelings, with emphasis on objective issues Avoid excessive familiarity	Generous validation of patient's concerns, with attentive but factual response to questions Allow patients to maintain sense of competence by re-channelling their "skills" to deal with illness, obviating need for devaluation of caregivers	Provide reassurance and schedule frequent periodic check-ups Be consistently available but provide firm realistic limits to availability Enlist other members of the health-care team in providing support for patient Help patient obtain outside support systems Avoid hostile rejection of patient	Thorough history taking and careful diagnostic work-ups are reassuring Give clear and thorough explanation of diagnosis and treatment options Do not overemphasize uncertainties about treatments Avoid vague and impressionistic explanations Treat patient as an equal partner; encourage self-monitoring and allow patient participation in treatment



ples of this would be treatment of depression or anxiety disorders in patients with personality disorders. Pharmacotherapy and psychotherapy (and their integration) are often more complex for patients with comorbid Axis I and II disorders. This difficulty is particularly evident when patients with personality disorders have concurrent substance-abuse problems or psychotic symptoms (eg, hallucinations, delusions, paranoid ideation). In such cases, mental health consultation can be particularly helpful.

When a provider feels unable to continue productive work with a patient with a personality disorder, it may be appropriate to transfer the patient to another clinician. Although such transfers of care may be both necessary and helpful, they require consideration of the impact of the transfer on the well-being of the patient. Patients with certain personality disorders may experience such transfers as rejection or abandonment, perceptions that may exacerbate their emotional distress and may potentially disrupt their medical treatment. Prior consultation with a mental health provider can be useful in determining whether such a transfer might be helpful and can aid in carrying it out smoothly.

The remainder of this chapter discusses eight personality disorders commonly encountered in the primary care setting.

## PARANOID PERSONALITY DISORDER

### Symptoms & Signs

Patients with paranoid personality disorder (Table 25-2) have a long-standing pattern of distrust and suspiciousness. They perceive the behavior and motives of others as malevolent in nature and expect, in many situations, to be disappointed or taken advantage of. They may perceive seemingly benign or innocuous statements or behavior by others as threatening, insulting, or hurtful. In order to defend against their perceived vulnerability, they usually adopt a rigid, dis-

tanced, or guarded position. In general, persons with this personality structure find intimate relationships undesirable and difficult, which often leaves them without any significant social supports.

### Differential Diagnosis

Long-standing psychotic symptoms, such as delusions and hallucinations, suggest a diagnosis of paranoid delusional disorder or paranoid schizophrenia. Although persons with paranoid personality disorder usually do not have frank paranoid delusions, at times of extreme stress they may develop such symptoms. Brief paranoid ideation may be associated with medical causes or with alcohol or substance abuse or withdrawal.

### Illness Experience & Illness Behavior

Illness is difficult for the individuals with paranoid personality disorder, because having to communicate personal information to the physician may challenge the self-protective, rigid way they approach social interactions. Patients may experience a heightened sense of vulnerability and fear of harm by the physician. In their fearful states, they may perceive innocuous or even overtly helpful behavior as threatening. They may then question or challenge the physician about the content of an intervention or the motives behind it. This can lead to possible conflict and argument between patient and doctor.

**The Doctor-Patient Relationship:** Physicians confronted with such a paranoid stance may react in ways that exacerbate the situation. Physicians who feel inappropriately suspect in their intentions might argue with the patient or become defensive, perhaps using an angry tone. This kind of reaction may frighten the patient and may be perceived as confirmation of the patient's suspicion. Although such a response should be avoided, ignoring the patient's distrustful or angry behavior can also be problematic; the patient's concerns, however irrational, may increase if not addressed.

Table 25-2. Diagnostic criteria for paranoid personality disorder (301.0).

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|---|
| <p>A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her</li> <li>2. is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates</li> <li>3. is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her</li> <li>4. reads hidden demeaning or threatening meanings into benign remarks or events</li> <li>5. persistently bears grudges, that is, is unforgiving of insults, injuries, or slights</li> <li>6. perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack</li> <li>7. has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner</li> </ol> <p>B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, or another psychotic disorder and is not due to the direct physiologic effects of a general medical condition.</p> |
|---|

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### Specific Management Strategies

It is essential to address the patient's concerns and fears empathically, however irrational they seem. Although the physician may see the patient's concern as unrealistic, to the patient the fear is real. Dismissing these patients' concerns or calling them paranoid will not address their emotional needs and may instead create distance in the doctor-patient relationship. A professional stance is most reassuring to these patients. Excessive friendliness or reassurance may be misinterpreted and may intensify their paranoia. It is important to give these patients detailed information about their proposed treatment plan, allowing them to feel they are in control of the treatment and can make independent decisions. Provide factual information about risks associated with the treatment, whenever possible, before any major procedures or changes and in treatment.

**Case illustration 1:** Simon, a 42-year-old, single, male parking lot attendant, presents to his primary care provider, complaining of 3 months of tension headaches and fatigue in the context of what he calls "job stress." The only notable finding in the physical examination is a new, but mild, elevation of blood pressure. The physician also observes that Simon seems angry and anxious, in contrast to his previously distant and somewhat guarded demeanor. When asked about his job stress, Simon reveals anxieties about not being able to trust two new coworkers, along with fears that his supervisors are conspiring to dismiss him from his job. He also mentions, hesitantly, that he had not sought evaluation of his headaches sooner, because he worried that the physician would dismiss his fears as unfounded or "crazy." Additional social history reveals difficulty with close relationships and recurrent problems adjusting to changes in the workplace.

The physician responds by listening in a nonjudgmental and empathic manner. She prescribes an over-the-counter analgesic for the headaches and lorazepam, 0.5 mg every 4–6 hours for occasional anxiety and agitation. She plans follow-up measurements of the blood pressure and suggests that Simon see a psychiatrist for further evaluation of his very stressful job situation.

Simon feels that his concerns have been taken seriously. He finds the referral to a psychiatrist acceptable

because it has been proposed in a way that offers support and does not dismiss his fears as pathological. The physician's matter-of-fact responses to Simon's somatic complaints help increase the patient's trust in his physician.

## SCHIZOID PERSONALITY DISORDER

### Symptoms & Signs

Individuals with schizoid personality disorder (Table 25–3) remain detached from social relationships and exhibit a restricted range of emotional expression in their interactions with others, often appearing cold or indifferent. Because patients with this disorder find emotions, intimacy, and conflict as threatening, they tend to isolate themselves and avoid close or sexual relationships. They prefer dealing with technical or abstract concepts to contact with people, and so they may devote their time to pursuits such as mathematical games. Work can be problematic if it involves interactions with others, but many individuals can perform quite well if they work with some degree of independence.

### Differential Diagnosis

Patients with schizoid personality disorder do not exhibit prolonged psychotic symptoms. They may, however, suffer a brief psychotic decompensation during times of extreme stress. In addition, schizoid personality disorder may in some cases precede the development of psychotic Axis I conditions, such as schizophrenia or delusional disorder. It can also coexist with schizotypal, paranoid, or avoidant personality disorders.

### Illness Experience & Illness Behavior

Illness can be especially stressful for these patients because it gives rise to strong emotions that they are not prepared to deal with. The necessity of interacting with caregivers when ill, often around quite personal issues, forces them to do the very thing they systematically avoid. They may therefore delay seeking care until their symptoms become more serious. When

**Table 25–3.** Diagnostic criteria for schizoid personality disorder (301.20).

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|--|
| <p>A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. neither desires nor enjoys close relationships, including being part of a family</li> <li>2. almost always chooses solitary activities</li> <li>3. has little, if any, interest in having sexual experiences with another person</li> <li>4. takes pleasure in few, if any, activities</li> <li>5. lacks close friends or confidants other than first-degree relatives</li> <li>6. appears indifferent to the praise or criticism of others</li> <li>7. shows emotional coldness, detachment, or flattened affectivity</li> </ol> <p>B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder and is not due to the direct physiologic effects of a general medical condition.</p> |
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Source: Reprinted, with permission, from American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*. American Psychiatric Association, 1994.

inconsiderate, angry, or harmful behaviors. These individuals may present themselves in a superficially grandiose manner, and they can also initially appear somewhat charismatic, until others recognize their charm as manipulative.

### Differential Diagnosis

Antisocial personality disorder can overlap significantly with other personality disorder traits, most commonly narcissistic, histrionic, or borderline personality disorder. Because substance abuse is a frequent comorbid diagnosis, it is important to distinguish between the problems when making the diagnosis.

### Illness Experience & Illness Behavior

In order to mask the fear that illness may cause, patients with antisocial personality disorder may unconsciously adopt an excessively self-assured, entitled, or hostile stance. Irresponsible, impulsive, or dangerous health behavior may help these patients deny their vulnerability to illness. This behavior can occur without regard for medical consequences, and many patients show blatant disregard for the health-care personnel and resources from which they have benefited. Patients may assume a privileged, self-deserving stance and can become antagonistic if they fail to obtain the desired response. They may attempt to manipulate their physician, malingering to obtain things such as drugs or inappropriate disability benefits. This behavior can be an embellishment of a real illness, or it can occur when they are not ill.

**The Doctor-Patient Relationship:** Since these patients often behave in ways that are noncompliant, ungracious, or dishonest, they are frequently irritating to health-care providers. Physicians may become angry with these individuals or reject them if they see that the treatments in which they have invested their knowledge and energy have not been followed, or if they discover they have been manipulated by these patients.

### Specific Management Strategies

Managing manipulative patients can be particularly challenging. If the patient tricks the physician, the outcome is usually detrimental to the patient's overall health (broadly defined). On the other hand, although recognizing the manipulative behavior may avert a detrimental health outcome, the physician's confrontation can alienate the patient. The more authoritarian the physician's stance, the more likely it is that the patient will become oppositional, reducing the possibility for development of an effective therapeutic alliance.

The key here is to maintain an objective, thorough, nonauthoritarian, and respectful approach to investigating patients' presenting complaints. If their patients' presentation or motives are suspicious, the provider should gather corroborating data from collateral sources (other providers or family members)

when needed. It is important to avoid becoming angry, punitive, or rejecting toward the patient; these behaviors may recapitulate behavior the patient experienced earlier in life that contributed to the development of the antisocial personality disorder. Such behavior by the physician can cause the patient to become hostile, with additional deterioration in the doctor-patient relationship. If confrontation or disagreement is necessary, it is essential to avoid humiliating the patient while identifying the attempted manipulation. Communication should be direct and factual with these patients, based on what is medically indicated, and set clear limits on the diagnostic or treatment plan.

*Case illustration 3:* On her return from vacation, the doctor's first patient is Randy, an angry 42-year-old man, well known to her for his problems with long-standing recurrent low back pain. Although his back pain is generally well controlled with back exercises and as-needed nonsteroidal analgesics, Randy frequently takes long motorcycle trips with friends, during which he does not exercise or take his analgesics. While the physician was away, Randy went on a motorcycle tour and had a recurrence of acute back pain. He then telephoned the clinic and became angry and abusive toward the on-call nurse practitioner, who would not submit to his demands for narcotics.

The physician, who has seen similar behavior from Randy in the past, listens carefully to his story, acknowledges his anger, and reflects empathically on how painful his back must be. She inquires, nonjudgmentally, about the reasons for his failure to exercise. She then explains the benefits of a more preventive approach—using exercise and avoiding pain-inducing behaviors—compared with the long-term risks of relying on narcotics and failing to exercise. Finally, she offers him referral to a physical therapist for a review of the exercise plan, along with a refill of his nonsteroidal analgesic, emphasizing her view that this would offer the best long-term outcome. Though with some bitterness, Randy acknowledges the benefits of the physician's recommendations and agrees to try to follow through with them.

In dealing with Randy, the physician uses her past experience with him to guide her. Randy's self-destructive behavior, hostility, and disregard for others are met with clear limit-setting by the physician, who responds in a calm and nonpunitive manner, emphasizing her concern for the patient's long-term well-being.

## BORDERLINE PERSONALITY DISORDER

### Symptoms & Signs

Patients with borderline personality disorder (Table 25-5) exhibit instability in their self-image, their affect, and their relationships with others. They can be

they finally present for medical attention, they may appear indifferent or detached as a way of protecting themselves from overwhelming emotion. They may show little facial expression and may not respond in kind to caregivers' empathic nods or comments—which may make establishing a therapeutic relationship difficult.

**The Doctor-Patient Relationship:** Since these patients often appear cold or indifferent, physicians may consider them as unappreciative of help. They may also be puzzled or frustrated by their patients' delay in seeking medical care and their apparent passivity in the face of illness. As a result, caregivers may make overzealous attempts to connect with patients by trying to be especially empathic, a tactic that may instead frighten them away. On the other hand, providers may themselves draw back and lose their enthusiasm for helping patients who seem so unappreciative or uninvolved in their own treatment.

### Specific Management Strategies

Understanding that individuals with schizoid personality disorder have difficulty tolerating emotions and intimate interactions is important. Physicians should appreciate their patients' need for privacy and should maintain a low-key approach, avoiding attempts to reach out by becoming too close or by insisting on providing social support. It is helpful to focus on the more technical aspects of treatment, since these are better tolerated, and encourage patients to maintain daily routines. Caregivers should remain available and provide steady but nonthreatening help.

**Case illustration 2:** Ben, a 44-year-old computer programmer, presents to a university outpatient clinic for evaluation of nausea, anorexia, and a 30-pound weight loss occurring over the previous several months. When asked why he hadn't sought treatment before, Ben states that he has always been healthy and thought he would probably regain the lost weight.

Throughout the interview, Ben makes poor eye contact and gives brief answers to questions. He appears to

dislike being interviewed by both a medical student and a resident. He becomes more uncomfortable when asked questions about his personal life and how he likes spending his time. Ben states that he usually keeps to himself, with the exception of visiting his sister about once a month. He spends much of his time programming and playing with his computer.

Ben appears visibly anxious when the resident recommends a consultation with a gastroenterologist. He asks whether this is truly necessary, since it will be hard for him to take time off from work. The resident emphasizes the importance of this consultation, and Ben seems to calm down a bit when the conversation focuses more on the possible tests that might be done to evaluate his symptoms, thereby distracting his attention from his concerns about having to see yet another doctor.

The resident later explains to the medical student that it is important to minimize the number of doctors Ben sees over time and to avoid an overfriendly style—which might frighten him.

## ANTISOCIAL PERSONALITY DISORDER

### Symptoms & Signs

Persons with antisocial personality disorder (Table 25-4) demonstrate a disregard for others and behavior that violates others' rights. The diagnosis can be made only in persons over age 18, and it requires a history of conduct disorder prior to that age. Characteristics include lack of conformity to social norms and laws, using lies or other deceitfulness for personal gain, and impulsiveness and irresponsibility in many settings. These individuals may be threatening, manipulative, or harmful to others, and they are generally not remorseful. Their tendencies toward aggressive behavior may not be immediately evident, but contact with collateral sources frequently reveals a criminal record. These character traits affect relations with both strangers and family alike, as persons with antisocial personality disorder may engage in

Table 25-4. Diagnostic criteria for antisocial personality disorder (301.7)

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
  1. failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  2. deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  3. impulsivity or failure to plan ahead
  4. irritability and aggressiveness, as indicated by repeated physical fights or assaults
  5. reckless disregard for safety of self or others
  6. consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  7. lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- B. The individual is at least age 18 years.
- C. There is evidence of conduct disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.

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**Table 25-5.** Diagnostic criteria for borderline personality disorder (301.83).

- A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. frantic efforts to avoid real or imagined abandonment; *Note:* Do not include suicidal or self-mutilating behavior covered in criterion 5.
  2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  3. identity disturbance: markedly and persistently unstable self-image or sense of self
  4. impulsivity in at least two areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating); *Note:* Do not include suicidal or self-mutilating behavior covered in criterion 5.
  5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
  6. affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
  7. chronic feelings of emptiness
  8. inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
  9. transient, stress-related paranoid ideation or severe dissociative symptoms

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quite impulsive and may engage in self-destructive behaviors, such as substance abuse, self-mutilation, and suicide attempts. These behaviors reflect a deep sense of emptiness and an intense fear of abandonment by others. On the other hand, patients with borderline personality are often also fearful of closeness. They experience many contradictory emotions and feelings that are not integrated into a stable sense of who they are and that may be associated with rapid shifts in mood. This instability can cause rapid changes in goals and values. These patients usually have difficulty differentiating reality from fantasy and tend toward all-or-nothing thinking in their view of themselves and others, alternating between overidealization and devaluation.

### Differential Diagnosis

Some patients with borderline personality disorder may suffer brief psychotic episodes when under stress. They may, for example, become very anxious or experience auditory hallucinations. Such episodes are distinguishable from Axis I psychotic disorders by psychotic symptoms of brief duration. In addition, patients with borderline personality disorder also often suffer from a concurrent Axis I mood disorder, such as major depression, which should, of course, be treated. Other personality disorders (eg, histrionic, or narcissistic) may be confused with borderline personality disorder. Some patients, however, may have traits of more than one personality disorder.

### Illness Experience & Illness Behavior

Patients with borderline personality disorder have difficulty distinguishing reality from fantasy, and they may have terrifying fantasies about illness. The complex and contradictory feelings engendered in response to illness can be intolerable to these patients, so they may try to cope by pretending that they are completely well and denying the presence of illness. Alternatively, they may become convinced that they are deathly ill, even when suffering from a mild ill-

ness. Having felt wounded in earlier relationships, individuals with borderline personality disorder mistrust and fear caregivers. In an attempt to cope with their simultaneous intense wish for, and fear of, closeness, they tend to conceptualize caregivers as all-good or all-bad—a mechanism called “splitting.” To complicate things further, these conceptualizations are not stable. Even an overidealized caregiver can abruptly be devalued if a borderline patient becomes angry and disappointed or feels abandoned. In addition, patients with borderline personality disorder may respond to feeling overwhelmed by engaging in impulsive and self-destructive acts, such as self-mutilation, substance abuse, and suicide gestures or attempts. They may also be noncompliant with treatment as a way to remain ill and thus maintain an ongoing relationship with the caregiver.

**The Doctor-Patient Relationship:** A common mistake clinicians make in treating patients with borderline personality disorder is getting too emotionally close. This occurs when clinicians feel intensely drawn to help the patients through their suffering and spend a great deal of time with them. This usually causes overstimulation of the patient’s emotions, leading to increased instability and acting out. It should be noted that the patient’s emotional behavior can cloud the clinician’s judgment, causing him or her to succumb to the patient’s idealization and splitting. The borderline patient’s self-destructive or often-provocative behaviors can cause despair and helplessness in caregivers. The caregivers may also feel tempted to punish the patient, for example by becoming verbally hostile or withholding needed pain medication.

### Specific Management Strategies

While providing basic support and reassurance, clinicians should be careful not to become emotionally overinvolved with the borderline patient. It is appropriate to counter the patient’s frightening fantasies about illness by scheduling frequent periodic check-ups and providing clear, nontechnical answers to

questions. Caregivers may have to tolerate periodic angry outbursts, but it is appropriate to set firm limits on both the patient's disruptive behavior and on the caregiver's response. When a multidisciplinary team of clinicians is involved, meetings of all providers should be arranged, to allow them to vent their feelings about the patient and to reach consensus on a treatment plan. It is helpful to select a small number of caregivers to interact with the patient directly and to present the same clear and consistent plan. This approach often prevents splitting. Finally, it is essential to remain aware of these patients' potential for self-destructive behavior and not to retaliate for their disruptions by displaying anger at them when setting limits.

**Case illustration 4:** A primary care resident expresses concern about her patient Amanda to her clinic's attending physician. She is scheduled to leave the clinic in 3 months and believes that Amanda will find transferring to a new doctor difficult.

Amanda is a 35-year-old temporary clerical worker with a long-standing history of migraine headaches. She often delays taking medication until her migraine headaches become severe, and then calls the resident, complaining of unbearable pain, and sometimes stating that the pain is so intolerable that she wishes to die. She sometimes comes to the clinic without a scheduled appointment, demanding to be seen right away. On the other hand, she often misses regularly scheduled appointments. During her visits, she expresses a fear of becoming homeless; she house-sits at other people's homes, but doesn't have a stable place of her own.

The resident asks for a psychiatric consultation to help her work with Amanda. She is particularly concerned about Amanda's periodic statements that she wishes to die.

Following the psychiatrist's recommendations, the resident continues to schedule regular, brief follow-up appointments, and encourages Amanda to keep these appointments. She explains that this is not a walk-in clinic, and that Amanda will have to seek treatment for acute pain in the emergency room. She also reminds Amanda that taking medication early will likely keep the headache from becoming very intense.

Other helpful interventions include providing increased support to Amanda by referring her to a psy-

chotherapist and asking the team social worker to assist her in finding a stable residence. It is also important to monitor Amanda for suicidal ideation. If she expresses a wish to die, the resident assesses her suicidal ideation and intent. Amanda drops in at the clinic expressing suicidal ideation, and a nurse practitioner calls for an urgent psychiatric consultation. After talking to the psychiatrist, Amanda gradually calms down and denies any suicidal intent; however, she refuses a referral for ongoing psychiatric treatment.

Over time, Amanda continues to miss some appointments, and occasionally becomes demanding or complains bitterly about the resident to the nurse practitioner. When both the resident and the nurse practitioner, however, firmly and supportively continue to reiterate their treatment plan—to meet with the doctor for regular appointments, to treat migraines early, and to go to the emergency room for acute pain—Amanda's unpredictable visits and noncompliance diminish. Periodic meetings between the resident and the nurse practitioner help them both present the same coherent plan to Amanda, thus minimizing splitting.

In planning ahead for her departure from the clinic, the resident and the attending physician discuss some helpful strategies to facilitate this transition, such as introducing the new resident to Amanda ahead of time and involving the nurse practitioner—who is staying at the clinic—in the process.

In this case, regular meetings of the resident, the attending physician, and the nurse practitioner allow them to present the same coherent plan to the patient, minimize the splitting, and reduce the patient's anxiety and unpredictable behavior. This approach successfully combines increased support and limit-setting.

## HISTRIONIC PERSONALITY DISORDER

### Symptoms & Signs

Histrionic personality disorder (Table 25-6) is marked by excessive attention seeking and emotionalism. These patients may present with dramatic, theatrical shows of feeling, or they may dress or behave in a sexually provocative fashion in an unconscious effort to engage others and draw attention to them-

**Table 25-6.** Diagnostic criteria for histrionic personality disorder (301.50).

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. is uncomfortable in situations in which he or she is not the center of attention
2. interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3. displays rapidly shifting and shallow expression of emotions
4. consistently uses physical appearance to draw attention to self
5. has a style of speech that is excessively impressionistic and lacking in detail
6. shows self-dramatization, theatricality, and exaggerated expression of emotion
7. is suggestible, ie, easily influenced by others or circumstances
8. considers relationships to be more intimate than they actually are

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selves. The emotions they express may be shallow and inconsistent, but the patients may still believe that the sharing of those feelings creates a special closeness (which they often exaggerate) with the physician. These patients have a tendency to prefer subjective and intuitive impressions over objective, linear, logical thinking. They often have somatic complaints, with impressive—but inconsistent—presentations.

### Differential Diagnosis

Histrionic personality disorder may be difficult to distinguish from narcissistic or borderline personality disorder, and patients in each of these categories may exhibit traits common to patients in the others. Patients with histrionic personality disorder are deeply affected by perceived frailties in relationship bonds, as are patients with borderline personality. The latter, however, display less emotional stability and are more impulsive and self-destructive. Patients with histrionic personality disorder may crave attention—as patients with narcissistic personality disorder crave admiration—but the former tend to be less grandiose, arrogant, and self-absorbed.

### Illness Experience & Illness Behavior

Medical illness represents a particular threat to the emotional well-being of patients with histrionic personality disorder, who derive much of their sense of self-worth and personal desirability from their sense of physical attractiveness. To reduce the fear of being deemed less desirable by others, these patients may attempt to bolster their physical appearance or embellish their abilities.

As a result, patients of either gender may engage in flirtatious or seductive behavior. When they feel weak and vulnerable, they may express their emotions with more intensity, in an attempt to strengthen their bond with the physician. In addition, since these patients focus on feelings, rather than on carefully observed physical symptoms, they may present with a collection of loosely connected somatic complaints. Their descriptions of the symptoms may reflect their desire to capture the physician's interest.

**The Doctor-Patient Relationship:** In working with the histrionic patient, the physician may be drawn in by the patient's dramatic and somewhat dependent style, become overly involved, and perhaps embark on an excessive work-up. As the physician becomes increasingly engaged by the patient's style, the patient may then become anxious, distant, or non-compliant, puzzling and frustrating the physician. Alternatively, the physician then may instead pursue too cursory an evaluation, because of a lack of objective information, or out of frustration with the patient's emotional and vague style.

### Specific Management Strategies

Because the patient with histrionic personality disorder has an emotional (rather than a logical) style

and may display contrasting behaviors—that range from excessive anxiety about potentially minor symptoms to inappropriate indifference about significant medical problems—it is essential that the physician maintain an objective stance. The physician must offer a supportive and logical approach to the patient's problems. This requires being both sensitive to the patient's emotional concerns and sufficiently distanced to avoid any degree of closeness that the patient might misperceive as intimate or sexual.

*Case illustration 5:* Rita is 38-year-old, single, unemployed actress with lupus. She is excessively friendly and flirtatious with her 45-year-old male physician, calling him frequently with questions about her medical problems and dressing somewhat seductively for office visits. During these visits she asks for examinations of a variety of somatic complaints. Over time, the physician becomes increasingly uncomfortable. Finally, Rita complains that she would like more time to discuss her problems at each office visit, and asks the physician if he thinks her problems "deserve more time."

After reflecting on the chronicity of this pattern of behavior, the physician responds that Rita's medical problems are significant and deserving of attention. He states that he intends to evaluate each of them carefully, allocating time on the basis of his impression of their medical necessity. He also says that he understands that she would like more time to discuss her concerns, but that as a busy doctor he cannot make additional time available to her. He suggests, gently, that if he cannot provide adequate emotional support to her, he could refer her to a local clinic's health psychologist. Although she is rather disappointed, Rita is able to accept this limit-setting and continues to work with this doctor.

This approach is successful because the physician shows positive regard for the patient and her problems—while clearly setting the limits of the doctor-patient relationship.

## NARCISSISTIC PERSONALITY DISORDER

### Symptoms & Signs

Narcissistic personality disorder (Table 25-7) is characterized by a long-standing pattern of grandiosity, with a need for praise and admiration that stands out in contrast to a lack of sensitivity to the feelings of others. These persons may have an exaggerated sense of self-importance and social status. They may be driven toward attaining an idealized position in terms of social, personal, romantic, or career accomplishment. In this regard, they may be envious and potentially devaluing of others whose accomplishments they perceive as exceeding their own.

### Differential Diagnosis

Narcissistic personality disorder may be difficult to distinguish from borderline, antisocial, histrionic, or

**Table 25-7.** Diagnostic criteria for narcissistic personality disorder (301.81).

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (eg, exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of entitlement, ie, unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6. is interpersonally exploitative, ie, takes advantage of others to achieve his or her own ends
7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
8. is often envious of others or believes that others are envious of him or her
9. shows arrogant, haughty behaviors or attitudes

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obsessive-compulsive personality disorders, and in many cases it may overlap with these disorders. When the differentiation is unclear, identifying a high degree of grandiosity and a need for admiration can help clarify the diagnosis. In contrast to persons with borderline personality disorder, persons with narcissistic personality disorder have a more stable self-image and display less impulsiveness and sensitivity to relationship losses. In addition, persons with narcissistic personality disorder are generally less aggressive and deceitful than are persons with antisocial personality disorder, who also display evidence of childhood conduct disorder. Persons with histrionic personality disorder, in contrast, may be relatively more dramatic and emotional than are those with narcissistic personality disorder. Although persons with narcissistic personality disorder, like those with obsessive-compulsive personality disorder, may both be perfectionistic, the former often have a higher self-assessment of their accomplishments.

Clinicians must also be careful not to misdiagnose a person with transient hypomanic or manic grandiosity as having narcissistic personality disorder. Similarly, it is important to distinguish between narcissistic personality disorder and transient substance-related personality changes (eg, from central nervous system stimulants) or personality changes caused by a general medical condition.

### **Illness Experience & Illness Behavior**

Health problems are a particular blow to patients with narcissistic personality disorder. Illness threatens these patients' unconscious attempts to maintain an intrapsychic and external image of untarnished well-being and resiliency. Medical problems and physical limitations may disrupt this image, threaten their public personas, and leave them fearing disruption of their (unrealistically unchallengeable) sense of self. In an attempt to defend against this threat, patients may minimize the significance of symptoms or deny the presence of the illness. More commonly, as patients try to recapture their admired, idealized status, they may demand special treatment or ridicule the physi-

cian caring for them. These patients may devalue, criticize, or question the behavior or credentials of the treating physician, or they may fail to comply with treatment recommendations.

**The Doctor-Patient Relationship:** Narcissistic patients' arrogant and grandiose behavior, combined with demands for special treatment, can be extremely irritating to physicians. Reactions to these patients can take many forms. Sometimes, in an attempt to avoid conflict, physicians submit to the demands. With particularly critical patients, providers may feel frustration, resentment, and even anger. Frustration may be especially great if the physician expends special energy on behalf of a charismatic or demanding patient, only to later become the butt of unfair criticism. Physicians may reject or avoid the patient, withhold treatment, or respond in an angry manner—responses that can harm both the patient and the doctor-patient relationship.

### **Specific Management Strategies**

The most effective strategy for dealing with narcissistic patients is to be respectful and nonconfrontational about their sense of specialness and entitlement and to help them use their self-perceived talents in the service of their treatment. If narcissistic patients feel vulnerable and threatened by the illness, they are more likely to criticize and devalue the physician. Providers can appeal to the patients' narcissism by explaining that they chose a particular course of action because they believe it represents the best possible care—a course of action they feel the patients deserve. Physicians can further support the patients by validating their concerns about the illness and pointing to their patients' ability to respond competently to its challenges. This approach helps the patients feel more secure and able, allowing them to ally confidently with—rather than defensively attack—their physicians.

**Case illustration 6:** Maggie is a 44-year-old married female lawyer, who is quite prominent in the community and an unusually demanding patient. She becomes very angry with her male physician, whom she accuses of



not responding adequately to her complaints about menopausal symptoms. In fact, the physician has done all the necessary laboratory tests, has conferred extensively with the patient's gynecologist, and has answered numerous phone calls by the patient over a period of several months.

The physician, aware of Maggie's long-standing sense of entitlement and her extreme sensitivity to slights, responds by reviewing her concerns, discussing the treatment plan and rationale, and encouraging her to discuss some of her emotional reactions to this unexpectedly early menopause. He then emphasizes the special consideration he has put into her evaluation and treatment plan. He arranges more frequent office visits, and tells Maggie that he predicts a relatively good response to treatment, given her active involvement in her own care.

This response is reassuring to the patient, because it validates her concerns and satisfies her narcissistic feelings of entitlement.

## DEPENDENT PERSONALITY DISORDER

### Symptoms & Signs

Patients with dependent personality disorder (Table 25-8) have a pervasive and excessive need to be taken care of. They experience intense fear of separation and abandonment and feel great discomfort when they are alone. This leads to submissive and clinging behavior in their interpersonal relationships. These patients have difficulty making independent decisions without a great deal of advice and reassurance, and they are afraid of disagreeing with others.

### Differential Diagnosis

It is important to distinguish dependent personality disorder from the dependency that arises from panic disorder, mood disorders, or agoraphobia. Patients suffering from medical illnesses may also become very dependent on others, without having this disorder.

Dependent personality disorder can sometimes be confused with other personality disorders, and dependent personality traits may be the result of chronic substance abuse.

### Illness Experience & Illness Behavior

Patients with dependent personality disorder fear that illness will lead to both helplessness and abandonment by others. In their interactions with caregivers, they may become very needy and make dramatic demands for urgent medical attention. If the response is not what they wish, they may display angry outbursts at the physician. They may also blame their physical discomfort on others, including their physician. In addition, they may use addictive substances or overuse medications in a desperate attempt to obtain immediate relief from their suffering. Because receiving medical care may fulfill their wishes for attention from others, some dependent patients may unconsciously contribute to prolonging their illness, or—in some extreme cases—they may encourage unnecessary medical procedures.

**The Doctor-Patient Relationship:** Clinicians treating patients with dependent personality disorder may initially react with aversion to their patients' clingy and demanding behavior. Alternatively, clinicians may find it difficult to set limits on their availability and may try to provide reassurance by attempting to meet every demand, which ultimately leads to burnout or feelings of inadequacy. Eventually, the caregivers may react in a hostile fashion and openly reject these patients.

### Specific Management Strategies

Effective ways to provide reassurance to dependent patients and allay their fear of being abandoned include scheduling frequent periodic check-ups and being consistently available. It is nonetheless important to provide firm, realistic limits to this availability early on in treatment or as soon as the patient's dependent traits become apparent. To prevent burnout, enlist other members of the health-care team in providing support for the patient. In addition, physicians

Table 25-8. Diagnostic criteria for dependent personality disorder (301.6).

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|---|
| <p>A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. has difficulty making everyday decisions without an excessive amount of advice and reassurance from others</li> <li>2. needs others to assume responsibility for most major areas of his or her life</li> <li>3. has difficulty expressing disagreement with others because of fear of loss of support or approval. <i>Note:</i> Do not include realistic fears of retribution.</li> <li>4. has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)</li> <li>5. goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant</li> <li>6. feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself</li> <li>7. urgently seeks another relationship as a source of care and support when a close relationship ends</li> <li>8. is unrealistically preoccupied with fears of being left to take care of himself or herself</li> </ol> |
|---|

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should help these patients find outside support systems to lessen fears of abandonment. They must also be alert to the patients' potential contribution to prolonging their illness or to their possible abuse of substances or medications.

**Case illustration 7:** Terry, a 50-year-old divorced secretary repeatedly presents to her primary care physician complaining of various somatic symptoms, including dizziness, headaches, blurred vision, and leg pains. Repeated work-ups of her symptoms are negative, and her evaluation for major depression is negative. Further inquiry into Terry's life reveals that after her divorce 6 years ago, her daughter became the focus of her life. Even though her history of occasional somatic symptoms goes back to her teenage years, there had been no appreciable change until 2 years ago, when her daughter got married and left her home.

Terry makes frequent phone calls to her doctor. She usually sounds nervous, expresses concern about some new symptom, and asks for medication. The doctor decides to schedule regular follow-up appointments to address Terry's concerns. Terry often complains during office visits that there is not enough time to evaluate all her symptoms and laments that her daughter no longer has much time for her. Her doctor listens in a supportive manner and acknowledges that the available appointment time is limited, explaining how he will ultimately cover all the complaints. He also underlines the importance of continuing to meet for regular appointments. In addition, the doctor acknowledges Terry's increased sense of isolation after her daughter's marriage. He also evaluates Terry for possible major depression. He further suggests a referral to the clinic's social worker as a means of helping her pursue a volunteer activity and increase her social interactions.

This approach usually helps diminish the patient's anxiety and decreases the frequency of phone calls. If the patient's distress were not to improve with such interventions, a referral for psychotherapy and evaluation for a possible underlying anxiety disorder would be indicated.

## OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

### Symptoms & Signs

Individuals with obsessive-compulsive personality disorder (Table 25-9) are preoccupied with orderliness, perfectionism, and control. They are excessively concerned with details and rules, tend to be overly moralistic, and are usually focused on work to the exclusion of leisure. They find it difficult to adapt themselves to others and instead insist that others follow their plans. Their general inflexibility and restricted emotional expression betray an underlying fear of losing control. Because they can be indecisive, they feel distressed when faced with the need to make decisions.

### Differential Diagnosis

Obsessive-compulsive disorder (see Chapter 23) is distinguished from obsessive-compulsive personality disorder by the presence of actual obsessions (repetitive intrusive thoughts) and compulsions in the former. Sometimes, however, both disorders coexist in one patient, and obsessive-compulsive personality disorder can also be confused with other personality disorders.

### Illness Experience & Illness Behavior

Illness is threatening to persons with obsessive-compulsive personality disorder because it generates an intense fear of losing of control over bodily functions and emotions. Patients may experience extremely unsettling feelings of shame and vulnerability. They may also feel anger at the disruption of their usual daily routines by medical appointments and treatments. They may fear having to relinquish control to health-care providers. In the physician's office, their intense anxiety tends to drive them to ask repetitive questions and to pay excessive attention to detail.

**The Doctor-Patient Relationship:** Caregivers may react to patients with obsessive-compulsive personality disorder by becoming impatient at their

**Table 25-9.** Diagnostic criteria for obsessive-compulsive personality disorder (301.4).

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
2. shows perfectionism that interferes with task completion (eg, is unable to complete a project because his or her own overly strict standards are not met)
3. is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4. is overly conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5. is unable to discard worn-out or worthless objects even when they have no sentimental value
6. is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7. adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes
8. shows rigidity and stubbornness

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## Borderline Personality Disorder: Diagnosis and Management in Primary Care

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Patients with borderline personality disorder frequently present to primary care physicians. However, the personality disorder, while complicating medical treatment, is often undetected. Symptoms and clinical presentations of this disorder are described. Common co-morbid psychiatric conditions associated with borderline personality disorder

include depression and substance abuse. Physically self-damaging behaviors are also common among patients with this disorder. Guidelines for managing these patients in the hospital and ambulatory care clinic are provided.

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Patients with borderline personality disorder (BPD) frequently present to primary care physicians. However, these patients' personality disorders are often not recognized. Little data are available about the prevalence or clinical picture of these patients outside of psychiatric settings. The primary care physician may encounter BPD patients in the ambulatory care setting with one of three common presentations: (1) the patient with severe yet atypical depression in which depression is more of a mood state than a set of vegetative symptoms<sup>1,2</sup>; (2) the drug-seeking patient who has a history of substance abuse<sup>2</sup>; and (3) the demanding and aggressive patient who idealizes or devalues the physician's interpersonal skills or competence or both. In the inpatient setting, BPD emerges in the form of management problems. These patients may be disruptive, demanding, and noncompliant.<sup>1</sup> They often successfully provoke conflicts between physicians and their nursing staffs. Lastly, these patients are encountered in the emergency department, where they are most likely to be seen after a suicide attempt.<sup>3</sup> Although suicide should always be managed as a life-threatening condition, the BPD patient often exhibits self-mutilative behavior that is associated with a sense of psychological relief<sup>3</sup> or that communicates an interpersonal message. These suicidal episodes are often impulsive, and the patients may readily bring themselves to the emergency department.<sup>3</sup>

The purpose of this paper is to describe the diagnosis of BPD and its implications for primary care physicians. Clinical encounters with these patients may be confusing and emotionally intense. It is valuable for the physician to understand the behavior of these patients as reflecting a more pervasive personality syndrome. Equipped with this knowledge, the primary care physician can develop more effective strategies for managing BPD patients.

### Diagnostic Criteria

The criteria for borderline personality disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R),<sup>4</sup> are presented in Table 1. As is the case with all personality disorders, these borderline features emerge in a long-standing, maladaptive pattern of perceiving the world and relating to others. Personality disorders are most likely to be evident in interpersonal relationships.<sup>4</sup>

### Epidemiology

Data on the prevalence of personality disorders, in general, is somewhat inconclusive. DSM-III-R<sup>4</sup> states that the disorder is "apparently common" in an estimated 5% to 10% of the general population.<sup>5</sup> The disorder is significantly more prevalent among women than men.<sup>4</sup> Developmentally, the disorder first becomes evident in mid- to late adolescence.<sup>4,5</sup> It has been suggested that in contrast to patients with other personality disorders, BPD patients are likely to enter the mental health or substance

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Table 1. DSM-III-R Criteria for Borderline Personality Disorder\*

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation
2. Impulsiveness in at least two areas that are potentially self-damaging: eg, spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5])
3. Affective instability; marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days
4. Inappropriate, intense anger or lack of control of anger, eg, frequent displays of temper, constant anger, recurrent physical fights
5. Recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior
6. Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values
7. Chronic feelings of emptiness or boredom
8. Frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior covered in [5])

\*American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised*. Washington, DC: American Psychiatric Association, 1987:347. Reprinted with permission.

abuse treatment system during at least one period of their lifetime. Often the chaotic and intense interpersonal relationships that they exhibit socially are also enacted in psychotherapy.<sup>3</sup> Treatment encounters may be brief, intense, and unproductive.<sup>3</sup> However, a number of these patients have remained in long-term psychotherapy. Thus, a good deal is known about the clinical picture and history of this condition.<sup>6,7</sup>

### Etiology

Although DSM-III-R describes the disorder, it does not provide an etiological explanation. At present, there is no consensus on the etiology of this disorder. Although it has been suggested that borderline personality may have a nonspecific hereditary component in common with affective disorders, schizophrenia, or both, the evidence for genetic transmission is unclear.<sup>8</sup> However, as is the case with personality disorders in general, the BPD patient has usually experienced a dysfunctional developmental history.<sup>9,10</sup> Psychodynamic formulations center on parental neglect<sup>11</sup> or overinvolvement as well as the unpredictable oscillation between these two extremes.<sup>12</sup> Disruptive separation or permanent loss of the primary caretaker appears to be a frequent factor in these patients' developmental histories.<sup>10,11</sup> Recent studies have revealed a high frequency of child abuse, both physical and sexual, among adults with BPD.<sup>9,13</sup> Herman et al<sup>10</sup> found that 71% of BPD patients in an ambulatory mental health center reported histories of physical abuse, and 68% reported sexual abuse.

### Clinical Picture

While the etiology and diagnosis of borderline personality are complicated, the term *instability* is a concise summary label.<sup>3,5</sup> This instability exists in identity, mood, and relationships. While this is a clinically useful concept,

BPD is a heterogeneous condition, and instability will be manifested in a range of behaviors.<sup>14,15</sup>

Identity disturbance may take a variety of forms. The clinician may note that the patient does not have a clear focus for life goals toward a new career.<sup>11</sup> One week the patient may be planning on taking courses in college toward a new career, the next week planning to leave town to look for a new job, and the following week deciding to stay at the old job. This disturbance may take the form of merging with someone else's identity that the patient becomes extremely dependent on that individual.<sup>11</sup> Patients with BPD may feel that their lives and plans are inextricably dependent on the desires of others. The instability in identity can also extend to their own self-concepts. They are likely to view themselves alternately as "all good" or "all bad." Patients with BPD may reflect this instability in their own lives by being "good" in their work situations, in which they perform very competently, and "bad" in their interpersonal relationships, in which they are moody, demanding, and unpredictable.<sup>11</sup>

A second common feature of BPD is intolerance of being alone. Because of this, patients devote considerable energy to avoiding real or imagined abandonment. This pattern may emerge in several ways. For example, a man with BPD may call his girlfriend 20 times a day, go into a panic or rage if she is not immediately available,<sup>11</sup> and ask for a minute-by-minute account of her day. A pattern of instant intimacy is also common. The physician may encounter a BPD patient who asks a large number of personal questions such as where the physician lives, whether he or she is married, and how many children the physician has. This information typically has little relevance to the physician's ability to treat the patient's medical problems, and because of the patient's need for interpersonal contact, the physician is likely to experience a loss of normal social and clinical distance.

Patients with BPD may also exhibit a defense called

"splitting," the inability to integrate contradictory experiences.<sup>16</sup> When these patients make a mistake in a work situation or disappoint someone, they may become severely self-deprecating. The patients' view of themselves may dramatically oscillate between one of almost narcissistic entitlement and one of severe self-criticism. This intrapsychic process is also enacted interpersonally. The process of idealization alternating with devaluation is a common form that splitting takes. It may also become evident in an inpatient setting when a consultant and a primary care physician are working cooperatively with a BPD patient. The patient may label the consulting physician as cold, rejecting, and incompetent, while viewing the primary care physician as extremely sensitive and skillful.<sup>1</sup>

The primary care physician who sees a BPD patient on a regular basis may inadvertently be a focus for this symptom. For example, the physician who generally devotes considerable time to the BPD patient may find that on a day when he or she is somewhat rushed, the patient reacts with a barrage of criticism and hostility, effectively ignoring the previously good physician-patient relationship.

The splitting process often results in intense and unstable relationships.<sup>3</sup> In their personal lives, BPD patients often experience intense conflicts, which may include physical violence.<sup>17</sup> This divisiveness alternates with equally intense reconciliation. This pattern may be enacted with spouses, children, and lovers. The clinician is frequently surprised by the degree of rage that a BPD patient may feel toward a spouse or lover while simultaneously clinging to the relationship. Again, this pattern may be enacted with the primary care physician. The physician may experience the BPD patient as extremely critical and questioning of his or her professional competence. As a result, the physician may suggest that the patient transfer to another physician. The physician may be surprised to find that, despite the onslaught of criticism, the patient has no desire to change physicians.

The BPD patient may also demonstrate significant deficits in the area of impulse control.<sup>3</sup> These impulse control problems may take a number of forms including excessive drinking, drug use, overeating, overspending, and sexual acting out.<sup>2</sup> In general, these impulsive periods often follow an interpersonal loss and can be seen as a means of managing unpleasant affective states such as anxiety or dysphoria.

Physically self-damaging behaviors are also a common symptom of BPD.<sup>4</sup> These self-destructive acts have an unusual quality that is pathognomonic of the borderline personality syndrome: BPD patients may engage in behaviors such as slashing their wrists with razor blades, inflicting burns with cigarettes or lighters, or becoming

intoxicated and driving a car at high speeds. While the intent appears suicidal, the BPD patient is often not intending death.<sup>3</sup> Instead, the BPD patient often seeks an experience of physical pain or distress that, in turn, reduces tension and may briefly alleviate guilt.<sup>3,11</sup> These self-destructive acts frequently occur immediately after the patient has engaged in some form of impulsive acting out or has had a major interpersonal conflict.

The behaviors described represent several perspectives on BPD including cognitive,<sup>18</sup> psychodynamic,<sup>11,16</sup> and interpersonal.<sup>19</sup> These characteristics will not be present or evident in the same degree in all BPD patients. For example, many patients with this disorder maintain excellent long-term work relationships but cannot sustain intimacy in their personal lives. Similarly, some BPD patients will consistently respond to threatened abandonment by drinking, whereas others will engage in self-mutilation.

Major depressive disorder is the most common comorbid psychiatric condition with borderline personality. It has been estimated that there is a 40% to 60% overlap between depression and BPD.<sup>20,21</sup> However, other BPD patients will exhibit anxiety as the primary affective state.<sup>21</sup> Somatoform disorders and substance abuse or dependence are also common diagnoses that occur with BPD.<sup>1,2,11</sup>

## Clinical Cases

The following cases involved patients with BPD who presented in primary care settings.

### *Patient 1*

The patient was a 29-year-old white married woman who presented at the ambulatory care clinic, tearful and despondent. She said that she felt overwhelmed and was experiencing headaches. She stated that during the previous week she had quit a job after an altercation with a supervisor. The patient reported that she had held approximately eight jobs during the previous 3 years and either had been fired or had abruptly quit after some interpersonal conflict. She said that her stress was compounded by the fact that her husband did not sympathize with her work difficulties and was currently angry with her for quitting because of the resultant loss of income. She was ambivalent toward her marriage and said that she oscillated between loving and hating her husband several times during the course of each day.

Further inquiry revealed that the patient had been using pain medication, including Darvocet and Percocet, fairly regularly for the previous 5 years. She said that she

obtained the prescriptions from different physicians for a variety of conditions including painful menstruation, headaches, and backaches. The patient also said that she smoked 1 to 2 marijuana cigarettes per day. She was vague about her drinking history. She indicated that she periodically went to bars and drank to the point of intoxication, but she did not provide much information about the frequency of these episodes.

The patient married at 16 years of age after becoming pregnant. She said that her mother "threw her out of the house" on learning that she was pregnant. The patient's first husband was abusive, and the marriage ended after approximately 2 years. Soon after, the patient met her second husband to whom she was still married. This marriage was characterized by ongoing conflict, several reported extramarital affairs by both spouses, and numerous separations.

The patient had one previous psychiatric hospitalization of 10 days' duration, which occurred approximately 7 years before. Over the past 10 years, the patient made several suicide attempts with small amounts of nonprescription medication. She said that she was seen by a psychiatrist approximately 1½ years before the current consultation and was placed on an antidepressant medication, which she stopped taking after 1 week.

*Comment.* The patient's difficulty in generating a cohesive history could have been attributed to subtle cognitive deficits such as dissociative states, which have been associated with BPD.<sup>22</sup> The patient described having episodes of intense anger, impulsive patterns of sex and substance abuse, suicidal behavior, unstable work relationships, substantial marital conflict, and idealization alternating with devaluation, which are all DSM-III-R symptoms of borderline personality disorder.

Before reaching a diagnosis of BPD, it was necessary to consider several other conditions. This patient did exhibit substance abuse as a co-morbid condition. Although the patient's poor work history and pattern of soliciting controlled substances from multiple physicians was consistent with an antisocial personality, the presence of manipulative suicide attempts, intense affect, and ability to maintain a long-term (albeit conflictual) relationship with her husband was more compatible with a diagnosis of BPD.

The physician's initial goal was to develop rapport with the patient in order to facilitate substance abuse treatment. The patient's entry into a drug treatment program required four family practice clinic visits over the span of several months, during which her physician encouraged her to seek help for her problem. Stone<sup>7</sup> has recently documented the importance of aggressively treating substance abuse in patients with BPD.

## Patient 2

The patient was a 22-year-old white female college student who came to the emergency room after overdosing with approximately 25 nonprescription sleeping pills. She was stuporous and exhibited a number of self-inflicted cuts and scratches on the inside of her arms. She indicated that the overdose had been prompted by feeling "empty" because her roommate was rarely present. The roommate had recently begun staying overnight with a boyfriend. Approximately 20 minutes after ingesting the medication, the patient had asked another student to take her to the hospital. The patient indicated that she had begun scratching her arms with razor blades 2 months ago. She stated that the initial episode of self-mutilation occurred after a sexual encounter with a married man she had just met. She expressed a mixture of guilt and anger about the affair.

The patient was the youngest of two children. Her parents resided in a city approximately 200 miles away from the university. The patient described her mother as overprotective and as having actively discouraged the patient from moving away.

The patient did not report any history of psychiatric illness. On mental status examination, she was somnolent and stuporous. Otherwise, her mood was mildly dysphoric and her affect was somewhat hostile. She indicated that she took the pills because she wanted to "feel something." When pressed, she said that she did not want to die, but that she just felt empty. The patient stated that "everything is OK now" and became extremely angry when the physician indicated that it would be necessary for him to admit her to the hospital for psychiatric evaluation. No auditory or visual hallucinations were noted. The patient related a history over the previous several years of binge eating when she felt depressed or anxious. A review of her functioning during the past weeks did not reveal an obvious depressive syndrome. The patient was admitted to psychiatry for observation.

*Comment.* Although major depression was considered as a possible diagnosis for this patient, she did not meet DSM-III-R criteria for that disorder. The patient did exhibit BPD features. Some of her symptoms, however, such as self-mutilation, appeared to be of fairly recent onset. The patient's self-mutilative behavior appeared to be associated with guilt resulting from impulsive sexual behavior. This pattern of self-punishment is a common dynamic in persons with BPD and is almost exclusively found with this disease. Other BPD features exhibited by this patient included binge eating, impulse control problems, emptiness, and difficulty in tolerating being alone. The patient's apparent overinvolvement

with her mother, although not a DSM-III-R symptom, is also highly prevalent among persons with BPD.<sup>19</sup>

In contrast to depressed persons who have relatively clear suicidal ideation, the BPD patient's self-mutilative behavior often serves to reduce guilt without death as an intent.<sup>3</sup> The presence of diminished impulse control among BPD patients, however, may lead to inadvertent death. Patients with serious self-destructive behavior should always be evaluated for inpatient psychiatric admission.

### Patient 3

This patient was a 32-year-old white woman who was seen in the ambulatory care clinic. She had an extensive history of both insulin-dependent diabetes mellitus and hypertension, which had both been poorly controlled. The patient's presenting concern was frequent headaches.

By way of social history, the patient reported that she had been married for approximately 12 years. She and her husband had separated four or five times. The patient reported that she had a 13-year-old son and a 5-year-old daughter. The patient described an intermittent work history. She stated that she had worked as an aide in a number of nursing homes, and that her longest period of employment had been approximately 6 months. She said that she drank to the point of intoxication at least twice per month. She also reported that she smoked marijuana about 4 days out of the week. She stated that for approximately the past 10 years, she had frequently gone to bars and left with various men. These episodes were generally one-night sexual encounters. The patient indicated that when she was angry with her husband or was lonely, the pattern of binge drinking and having brief affairs tended to emerge.

During the interview, she exhibited considerable emotional lability, vacillating from anger to tearfulness to laughter. The patient indicated that she was supposed to be taking insulin on a daily basis, but was not taking it consistently and had not taken any for the past 3 weeks. She also stated that medication had been prescribed for hypertension, but that she was not taking it regularly either. The patient was not suicidal; however, she described cutting her wrists several times in the past. She reported frequent crying episodes and some fatigue, but no other depressive symptoms.

**Comment.** Acting out as an unconscious strategy for managing loneliness or potential abandonment is a common process with BPD patients. In addition to substance abuse, this patient demonstrated how BPD may interfere with treatment of chronic medical problems. It is likely that, psychologically, noncompliance with medication served a function similar to the patient's other self-de-

structive behaviors. The initial strategy in managing the patient was to develop a consistent relationship with the primary care physician, who encouraged her to ventilate her feelings but who also set specific expectations concerning medication compliance. The physician also discussed the self-destructive theme that he had identified, and explained that it had been manifested in the patient's noncompliance. The patient was referred to a psychologist for supportive psychotherapy. Her overall psychosocial functioning did not dramatically improve; however, within 3 to 4 months after the initial contact, her diabetes was under better control.

### Course of the Syndrome

Despite the large number of patients with BPD who receive both inpatient and outpatient psychiatric treatment, relatively little is known about the course of this disorder. Existing studies traditionally follow BPD patients after they have been discharged from an inpatient program. The majority of these patients studied continue to receive some form of psychotherapy for periods throughout their lifetime.<sup>7,23</sup>

Drawing on a cohort of patients with BPD who were discharged from a long-term inpatient facility, McGlashan<sup>24</sup> sketched a life history of the disorder. Generally, these patients manifested poor work and social functioning through their 20s and early 30s. Functioning improved and stabilized during their 40s. However, a subgroup of patients deteriorated during their late 40s and early 50s, usually in response to a divorce, death of a spouse, or dissolution of a significant relationship.<sup>24</sup>

The lifetime rate of completed suicide among persons with BPD is between 6% and 10%.<sup>7,23,25</sup> However, BPD patients with co-morbid conditions such as major depression and substance abuse manifest a substantially higher suicide rate. Patients with a concomitant depressive disorder exhibited a 15% to 20% rate of completed suicide.<sup>7</sup> Particularly striking is the 38% suicide rate during a 5-year period among female patients with BPD who had both co-morbid major affective disorder and substance abuse.<sup>7</sup>

### Treatment

Psychological treatment of BPD patients has included psychodynamic, cognitive-behavioral, family, and group therapies. There have been very few rigorous empirical outcome studies of treatment for BPD patients. The majority of treatment literature for this condition describes long-term individual psychodynamic psychother-



apy.<sup>16,26</sup> Several studies have compared supportive therapy, focusing on empathic reassurance and problem-solving about issues that arise in the patient's daily life, with expressive therapy that resembles more traditional psychodynamic therapy, including interpretation and linking the patient's internal states to his or her behavior.<sup>26</sup> Patients with BPD who had better quality interpersonal relationships appeared to improve more with expressive therapy, while patients who had poorer social connections improved more in supportive treatment.<sup>25</sup>

With respect to pharmacotherapy, it is important to recognize that personality disorders alone are not usually amenable to psychoactive drug treatment. These disorders are the product of a long social learning history rather than a biochemical or physiological process. However, BPD patients with common co-morbid conditions such as major depression or generalized anxiety often do benefit from medication.<sup>27,28</sup> Although controlled studies of medication response in BPD patients are few, there are suggestions that depressed patients with vegetative symptoms demonstrate improvement with tricyclic antidepressants and possibly with fluoxetine.<sup>7</sup> Similarly, BPD patients with generalized anxiety disorder in which autonomic symptoms predominate may benefit from short-term use of minor tranquilizers. Because BPD patients are at significant risk of committing suicide, tricyclics should be prescribed with caution and patients should be closely monitored. Similarly, the high prevalence of substance abuse among these patients suggests that anxiolytic medications such as alprazolam and diazepam should be used with caution.<sup>8,28</sup>

## Management in the Primary Care Setting

The primary care physician, while generally not in a position to perform long-term psychotherapy, will frequently encounter patients with BPD in practice. Table 2 presents a list of presenting clinical issues commonly associated with BPD patients in primary care settings.

As noted earlier, these patients rarely present clinically with BPD as a problem, but may exhibit depression, anxiety, or medical problems associated with substance abuse. In addition, the presence of BPD may complicate the treatment of nonpsychiatric medical problems. While the heterogeneity of this condition does not lend itself to a fixed protocol, some suggestions are offered below and summarized in Table 3.

1. Accurate diagnosis of depression and substance abuse may be more difficult among patients with concurrent BPD. Clinically, depression with an underlying per-

Table 2. Clinical Issues Associated with Borderline Personality Disorder

- 
- Clinical depression that is unresponsive to pharmacotherapy
  - Manipulative suicide attempts
  - Self-abusive behavior (eg, self-inflicted cuts or burns)
  - Noncompliance with treatment for chronic or acute medical problems with little apparent concern about consequences
  - Sense of entitlement, excessively demanding of physician time and attention
  - Disproportionate, intense anger toward physician
  - Broken bones or lacerations that were incurred during angry outbursts (eg, banging arm against a wall, smashing a window)
  - Patient "splits" physicians (eg, primary physician characterized as "all good" and consulting physician characterized as "all bad")
  - Physician becomes anxious or fearful of patient's emotional volatility
- 

sonality disorder often presents somewhat different from the classic acute depressive episode described in DSM-III-R. Generally, BPD patients have an extensive history of poor psychosocial functioning, with a similar long history of dysphoric mood. With BPD patient depression may take the form of a mood state rather than an easily identified set of vegetative symptoms. The likelihood of an underlying personality disorder should be one consideration when a patient does not respond to a reasonable trial of antidepressant medication. Clinically depressed patients with underlying BPD are likely to respond to antidepressants and exhibit improved vegetative functioning; however, mood swings and impaired psychosocial functioning are likely to persist.

Among BPD patients with concurrent substance abuse, the pattern of abuse is likely to be episodic rather than continuous. Patients with BPD are very likely to engage in binges of drinking and drug use, and therefore usually do not meet DSM-III-R criteria for substance dependence but do meet criteria for substance abuse.

2. The clinician should try to remain emotionally detached and neutral.<sup>3</sup> The physician may find that a BPD patient actively provokes him or her. The physician's emotional reaction may be to become angry or to reject the patient. It is important for the physician to recognize that the provocative behavior of such patients is part of their psychiatric condition and should be responded to in the same way as any other symptom. The level of emotional arousal is likely to be particularly high with the primary care physician since the physician is most likely to see them at crisis points.<sup>1,3,11</sup>

3. If the patient seems annoyed or angry with the physician, the physician should acknowledge these feelings.<sup>3</sup> The physician can then ask if there is anything



Table 3. Guidelines for Clinical Management of Patients with Borderline Personality Disorder in the Primary Care Setting

- Be aware that co-morbid borderline personality disorder may complicate accurate diagnosis of major depression and substance abuse.
- Remain emotionally neutral and avoid responding to provocation.
- Acknowledge the patient's anger, frustration, or annoyance.
- Respond to strong emotional outbursts with a verbal recognition of patient's feelings and a request for appropriate behavior.
- Actively structure the patient interview.
- Schedule patients with "abandonment issues" or somatization for frequent, brief office visits.
- Supportively confront medical noncompliance. Contracting with the patient may be helpful.
- Conduct physical examinations with a nurse present.
- Support psychotherapy for the patient.

he or she is doing that angers or agitates the patient. This response by the physician will enhance the patient's sense of control and decrease the patient's feelings of vulnerability.

4. The intense emotionality that many BPD patients exhibit is often initially overwhelming and anxiety-provoking for physicians and nurses. The response to the patient's emotional outbursts should include a recognition of the patient's feelings with a clear request for appropriate behavior ("I can see you are very angry. I can talk with you if you will lower your voice"). If the patient does not respond, the physician or nurse should terminate the conversation with the message that it will be resumed when the patient obtains some control.

5. The physician should actively structure the interview.<sup>3</sup> The thought processes of BPD patients are often diffuse. It is useful to give them a brief introduction, summary, and rationale for the clinical interview that you will be undertaking.<sup>3</sup> The greater the organization around the interview, the greater the level of security experienced by the BPD patient. This security should, in turn, diminish some of the clinician's anxiety regarding the patient's unpredictable volatility. For example, the physician should state, "First, I would like to ask you about your drug and alcohol use. Then I would like to ask you about your relationship with your husband." In addition, the clinician should label the patient's current behavior. A knowledge of the BPD patient's symptoms and dynamics will be extremely useful. This is particularly true for the patient's self-destructive acts, which may be experienced by the patient as frightening and masochistic self-injurious behavior. A primary care physician who is knowledgeable about the syndrome and who can communicate empathy and an understanding of the symp-

toms will greatly reduce the patient's fearfulness and dramatically increase rapport.

6. The BPD patient's fear of abandonment may be enacted with the primary care physician. The patient may repeatedly telephone the physician and appear in the office or emergency room as a means of "testing" the physician's availability.<sup>11</sup> The physician should verbally describe this pattern to the patient and label the underlying fear. It is often clinically useful and more efficient to schedule these patients for frequent brief office visits (eg, biweekly).

7. A similar clinical strategy with frequent office visits is useful for patients exhibiting BPD together with somatization disorder. For the patient with chronic rotating physical complaints, it is valuable to focus on a specific complaint at each visit in conjunction with a brief discussion of the patient's psychosocial circumstances. Over time, these patients may be able to appreciate the relationship between psychosocial stressors and somatic complaints.

8. The BPD patient with a chronic illness (eg, diabetes, hypertension) who is noncompliant should be supportively confronted. It is often therapeutic to label the self-destructive theme in the patient's noncompliant behavior. This should be followed by a discussion of the consequences of continued noncompliance and the physician's concern about the patient's health. Establishing a contract with the patient around compliance and appointments is often a valuable structuring device. It is often helpful to put these contracts in writing with a copy for the patient to take home.

9. When performing a physical examination, particularly a breast or pelvic examination, it is particularly important that the physician take all necessary precautions, including having a nurse present in the room. Patients with BPD have significant boundary problems and may misinterpret these procedures as indicative of a personal relationship rather than reflecting a medical examination.<sup>29</sup>

10. Once rapport has been established with the patient, the primary care physician may consider referring the patient for psychotherapy. Brief discussions of psychotherapy during the course of multiple office visits may be needed before the patient will seriously consider this option. Given the BPD patient's sensitivity to rejection, the physician should not present psychotherapy as a replacement for his or her own availability but, instead, as an additional support. It is helpful to predict to the patient that therapy will be difficult and that the patient is likely to get angry with the therapist and will want to stop treatment. Since this is, in reality, likely to happen, it will prepare the patient for when difficulty does occur in the psychotherapeutic relationship. In addition, it is

important for the primary care physician to support the patient's continued involvement in psychotherapy. This support can be provided simply by asking about the patient's course of psychotherapy and his or her feelings about it during each office visit. The patient may periodically deprecate the therapist or devalue the therapy. At these times, the physician should acknowledge the patient's discomfort while simultaneously continuing to support the patient's involvement in therapy.

## Conclusions

Patients with BPD frequently present to primary care physicians. However, the personality disorder itself often remains undiagnosed. The presence of BPD confuses the clinical picture in diagnosing or treating the depression, anxiety, and substance abuse that are more readily apparent. In addition, the internal dynamics and behavior of these patients may interfere with the treatment of acute and chronic physical illness.

By developing a working clinical knowledge of this disorder, the primary care physician will, it is hoped, be able to develop rapport with these patients. In addition, an understanding of the borderline syndrome can reduce the confusion, anxiety, and frustration that physicians often experience with these patients. While it is unrealistic for primary care physicians to provide long-term psychotherapy for BPD patients, the family physician can have a therapeutic effect by following the guidelines described above. By serving as a consistent, yet firm, physician who will "call" the patient on his or her self-destructive behavior, the primary care physician will be providing valuable psychosocial therapy.

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